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IN THE

Supreme Court of the United States

October Term, 1983

ST. FRANCIS HOSPITAL CENTER, ET AL.,

Petitioners,

vs.

MARGARET HECKLER, Secretary, Department of Health and Human Services and PROVIDER REIMBURSEMENT AND REVIEW BOARD, THOMAS TIERNEY, Chairman,

Respondents.

APPENDIX TO
PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SEVENTH CIRCUIT

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In The

United States Court of Appeals

For the Seventh Circuit

No. 82-2458

ST. FRANCIS HOSPITAL CENTER, et al.,

Plaintiffs-Appellants,

v.

MARGARET HECKLER,* Secretary, Department of Health and Human Services, & PROVIDER REIMBURSEMENT REVIEW BOARD, THOMAS TIERNEY, Chairman,

Defendants-Appellees.

Appeal from the United States District Court for the Southern District of Indiana, Indianapolis, Division.
Nos. 80 C 500, 80 C 89, 80 C 206, 80 C 272—**S. Hugh Dillin**, *Judge.*

ARGUED FEBRUARY 10, 1983—DECIDED AUGUST 12, 1983

Before BAUER, WOOD and ESCHBACH, *Circuit Judges.*

PER CURIAM. Sixty-eight nonproprietary hospitals ("the Hospitals") appeal from the district court's decision denying them reimbursement under the Medicare Act, 42 U.S.C. §§1395 through 1395pp, for a return on equity capital and for certain bad debt and charity expenses. 544 F. Supp. 1167 (S.D. Ind. 1982). We affirm the decision of the district court and adopt those portions of the court's

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* The name of the present Secretary is ordered substituted for the name of her predecessor, Richard S. Schweiker, according to Rule 43(c) of the Federal Rules of Appellate Procedure.

excellent opinion reproduced as an appendix to our opinion. We have deleted certain portions of the opinion, primarily those dealing with a separate suit that was not appealed and those addressing issues not raised on appeal. We add the supplemental sections immediately below to address arguments raised on appeal that are not specifically answered by the district court's opinion.

Standard of Review

In their attempt to secure a return on equity capital, the Hospitals were successful in convincing the Provider Reimbursement Review Board ("PRRB") that such a return was a "reasonable cost" for nonproprietary facilities. The Secretary, through the Deputy Administrator of the Health Care Financing Administrator, reversed this ruling and held that the Hospitals could not recover a return on equity. On appeal, the Hospitals contend that the district court erred in giving deference to the Secretary's interpretation of the statute and in failing to give adequate weight to the decision of the PRRB.

The standard of review for reimbursement decisions rendered under 42 U.S.C. §1395oo is found in "the applicable provisions under chapter 7 of Title 5." 42 U.S.C. §1395oo(f). Thus the standards of the Administrative Procedure Act, 5 U.S.C. §§701-706, govern. Section 706 provides that "the reviewing court shall decide all relevant questions of law, [and] interpret constitutional and statutory provisions...." The court must "hold unlawful and set aside agency action, findings, and conclusions found to be...arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law...." *Id.*

In the instant case, we do not have a challenge to any findings of fact—the facts are essentially undisputed. Neither do we have a dispute over the interpretation of an agency regulation. The present regulatory scheme denying return on equity for nonproprietary hospitals has been firmly and unambiguously in place since 1969. The

challenge the Hospitals raise is that the regulatory scheme is in violation of the Medicare statute and the Constitution.

We note at the outset that to the extent the Hospitals challenge the constitutionality of the statute or the regulatory scheme, their non-deference argument is unnecessary. Deference to administrative expertise does not extend to judging the constitutionality of a statute or regulatory scheme. As far as construing the Medicare statute, a court should give deference to the interpretation of the agency charged with administration of the statute. *See Blum v. Bacon*, 457 U.S. 132, 141 (1982); *Griggs v. Duke Power Co.*, 401 U.S. 424, 433-34 (1971). Congress has charged the Secretary of Health and Human Services ("HHS") with administration of the Medicare program. 42 U.S.C. §1395kk. Nevertheless, deference to the Secretary must yield to the clear meaning of the statute as revealed by its language, purpose and history. *See Southeastern Community College v. Davis*, 442 U.S. 397, 411 (1979).

The Hospitals suggest that these well established principles are altered in this case because the Secretary reversed the PRRB on the issue of return on equity capital. For support they point to *St. John's Hickey Memorial Hospital v. Califano*, 599 F.2d 803 (7th Cir. 1979), in which we declined to defer to the Secretary's determination that the costs of a certain educational program were not reimbursible [sic] under the Medicare regulations. In particular, the Hospitals point to the following passage:

> This special provision for judicial review [42 U.S.C. §1395oo(f)] is not surprising in light of the statutory scheme. Here the plaintiff is not the beneficiary of the government program, but a necessary participant in carrying out the program. The Secretary is obligated by statute to reimburse all reasonable costs of such providers. It would be inappropriate to allow his subordinates to be the final arbiter of what is reasonable, particularly when they have overruled the decision of the Provider Reimbursement Review Board which

> was set up to mediate disputes between providers and intermediaries acting for the agency.

Id. at 813 n.18.

This does not support the Hospitals' argument that the district court should have deferred to the *PRRB's* decision. Final responsibility for rendering a decision lies in the agency itself, not with subordinate hearing officers, and it is this decision that the district court reviewed. *See American Medical International, Inc. v. Secretary of Health, Education and Welfare*, 466 F. Supp. 605, 611 (D.D.C. 1979), *aff'd*, 677 F.2d 118 (D.C. Cir. 1981). The decision of the PRRB can be considered no more expert than the decision of the Secretary.

> Under 42 U.S.C.A. §1395oo(f) and 42 C.F.R. §405.1875 (1979), the Secretary, on her own motion and at her discretion, may review a decision of the PRRB and on review has all the powers she would have if making the initial determination. 5 U.S.C.A. §557(b). Thus the decision of the PRRB carries no more weight on review by the Secretary than any other interim decision made along the way in an agency where the ultimate decision of the agency is controlling. The argument that the court should recognize the expertise of the members of the PRRB must be met with the assumption that those persons within the agency who assisted the Secretary in a contrary decision must be regarded as being equally expert.

Homan & Crimen, Inc. v. Harris, 626 F.2d 1201 (5th Cir. 1980).

The Hospitals argue that the prior contrary decision of the PRRB lessens the degree of the deference due the *Secretary's* decision. We note first that the passage from *St. John's*, quoted above, is primarily a comment on the propriety of judicial review, and does not directly address the question of whether deference is lessened when the Secretary has reversed the PRRB. We did state in that case

that the degree of deference accorded the Secretary in implementing regulations varies with the circumstances of each case. *St. John's Hickey Memorial Hospital v. Califano, supra*, 599 F.2d at 812. In that case, we found *extreme* deference inappropriate when the court merely disagreed with an unofficial interpretation of a regulation. *Id.* In contrast, in the instant case, we are faced with the Secretary's judgment that her regulatory scheme denying a return on equity capital to nonproprietary hospitals, in place since 1969, is consistent with the statute she is charged with administering. In these circumstances, we believe the district court's deference to the Secretary's decision was appropriate.

Supplement—Is a Return on Equity Capital a Reasonable Cost for Nonproprietary Providers Under 42 U.S.C. §1395x(v)(1)(A)?

While we have adopted the district court's analysis on this point and the point following, we add these supplemental sections to answer arguments raised on appeal and not specifically addressed by the district court.

All providers are entitled to reimbursement of the "reasonable cost" of the services provided. 42 U.S.C. §1395f(b). Reasonable costs are defined generally in 42 U.S.C. §1395x(v)(1)(A), with authorization for the Secretary to prescribe regulations further defining reasonable costs. 42 U.S.C. §1395x(v)(1)(B), added in 1966, directs the Secretary to include in the regulations a provision for return on equity capital for *extended care services* provided by *proprietary* facilities. The Hospitals contend that the services of proprietary hospitals do not fit the literal language of §1395x(v)(1)(B), and therefore their return on capital must come under the general provisions for reasonable costs, §1395x(v)(1)(A). If a return on equity capital is a reasonable cost under this section for proprietary hospitals, the appellants argue that it is also a reasonable cost for nonproprietary hospitals.

The reasons Congress had for singling out proprietary facilities providing *extended care service* (*i.e.*, skilled nursing facilities) are not clear. The legislative history is scant. There is some indication, however, that Congress intended a return on equity capital to be extended to *all* proprietary providers. The Managers on the Part of the House submitted a statement to explain the recommended action of the committee of conference considering the proposed 1966 amendment. The committee recommended the amendment, which is now codified at §1395x(v)(1)(B), the house managers explaining:

> The conferees expect that the Secretary of Health, Education, and Welfare will apply similar or comparable principles in determining reasonable costs for reimbursement of proprietary hospitals for services furnished by them.

H. R. Rept. No. 2317, 89th Cong., 2d Sess., 166, *reprinted in* 1966 U.S. Code Cong. & Ad. News 3676, 3692-93.

The legislative enactments at issue here are not a model of clarity. However, they do not alter our conclusion that Congress did not intend a return on equity capital for non-proprietary providers to be reimbursable as a "reasonable cost" under §1395x(v)(1)(A). Any ambiguity we find goes to the issue of whether *proprietary hospitals* are entitled to such a return under either §1395x(v)(1)(A) or (B), an issue we need not decide at this point. We agree with the Secretary, the district court, and the other courts that have faced the issue presently before us—Congress did not intend nonproprietary facilities to collect a return on equity capital as part of the "reasonable cost" of providing services.

Supplement—Does the Statutory or Regulatory Scheme Violate the Just Compensation Provision of the Fifth Amendment?

The Hospitals argue that those cases in which the Supreme Court held government-prescribed rates to be

confiscatory, *e.g. Smyth v. Ames*, 169 U.S. 466 (1898), are directly analogous to the instant case. They correctly point out that the government cannot prescribe rates so low that the result is a taking of property without just compensation, *see id.* at 526, and that the government cannot defend setting low rates in one market segment by arguing that the regulated enterprise can set higher rates for another segment and thus turn a net profit, *see id.* at 541.

The Hospitals' argument might well prove persuasive if participation in the Medicare program were mandatory. However, Medicare is a federally sponsored insurance program for the aged and disabled, 42 U.S.C. §1395c, and provider participation is voluntary, 42 U.S.C. §1395cc. Providers who opt not to participate are free to serve persons not covered by Medicare and those potential Medicare recipients who are willing to forego Medicare benefits for the services provided. As a practical matter, perhaps few of those persons eligible for Medicare would choose a non-participating hospital, but the fact that practicalities may in some cases dictate participation does not make participation involuntary. Even those hospitals that have an obligation to participate in the Medicare program because of their receipt of funds under the Hill-Burton Act, 42 U.S.C. §291; 42 C.F.R. §124, made a voluntary choice to accept both the obligations and the benefits of Hill-Burton funding. *Cf. Johnson County Memorial Hospital v. Schweiker*, 698 F.2d 1347, 1350 (7th Cir. 1983) (Medicare does not reimburse for charity costs accrued under the Hill-Burton Act because "the government has already paid through contractual agreements for [that] indigent care"). We therefore find *Smyth v. Ames*, *supra*, and its progeny to be inapposite, and conclude, with the district court, that there has been no violation of the Fifth Amendment just compensation provision. *Cf. Pharmacist Political Action Committee v. Harris*, 502 F. Supp. 1235, 1242-43 (D. Md. 1980) (Maximum Allowable Cost regulations for prescription drugs dispensed under Medicare and Medicaid programs did not constitute taking

of property, in part because participation in programs is voluntary).

Conclusion

The Hospitals and the amici curiae, the American Hospital Association and the Catholic Health Association of the United States, have presented strong arguments in favor of allowing nonproprietary hospitals a return on equity capital under Medicare. Those arguments, however, are made to the wrong forum. This court cannot require what may seem wise, but only what is required by the Medicare statute and the Constitution. Having found that neither the statute, due process or equal protection requires a return on equity capital for nonproprietary hospitals, we affirm the district court's judgment and adopt those portions of the district court's opinion reproduced below.

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF INDIANA
INDIANAPOLIS DIVISION

ST. FRANCIS HOSPITAL CENTER, et al.,	)	
Plaintiffs,	)	
v.	)	No. IP 80-89-C
	)	No. IP 80-206-C
RICHARD S. SCHWEIKER, Secretary Department of Health and Human Services,	)	No. IP 80-272-C
	)	No. IP 80-500-C
PROVIDER REIMBURSEMENT REVIEW BOARD, THOMAS TIERNEY, Chairman,	)	
Defendants.	)	

MEMORANDUM OF DECISION

* * *

The facts and legal issues presented by these cases are complex and will be dealt with in greater detail in the body of this memorandum. In brief, these suits present challenges to Medicare reimbursement statutes, regulations and policies by 68 Indiana hospitals and the Indiana Hospital Association, Inc., to which the 68 hospitals belong.

The hospitals claim that they are entitled to reimbursement of the portion of their return on equity capital and bad debt and charity costs that they claim are attributable to

the Medicare patients they treat. The Medicare Act was passed in 1965. 42 U.S.C. §§ 1395, *et seq.* It provides for the reimbursement of the reasonable cost of providing services to Medicare beneficiaries. 42 U.S.C. §1395f(6). The statutory definition of "reasonable cost" is found at 42 U.S.C. §1395x(v)(1)(A). Pursuant to the Medicare Act, the Secretary of Health and Human Services (hereinafter "the Secretary") has promulgated regulations which define the concept of reasonable cost more fully. 42 U.S.C. §1395hh; and 42 C.F.R. §§405.401-405.488.

The 68 plaintiff hospitals have all made claims for reimbursement for return on equity capital and bad debt and charity costs for a variety of fiscal years with the "fiscal intermediary" which acts as the agent of the Secretary pursuant to 42 C.F.R. §405.651. The fiscal intermediary which rules upon claims made by Indiana hospitals (termed "providers" under the Act) is Mutual Hospital Insurance, Inc. d/b/a Blue Cross of Indiana.

These plaintiffs filed claims ("Cost Reports") with Blue Cross. Blue Cross, by "Notices of Program Reimbursement" to each of the hospitals, denied payment under the Medicare Act for the return on equity, bad debt and charity claims. The hospitals then pursued the administrative appeals outlined by the Act and the Secretary's regulations. 42 U.S.C. §1395oo(a); and 42 C.F.R. §405.1837. The plaintiffs were granted permission to pursue their appeals as a group appeal, since their claims presented common questions of law.

The first level of appeal was to the provider Reimbursement Review Board ("PRRB" or "Board" hereafter). The PRRB ruled that the hospitals were entitled to a return on the equity, but sustained Blue Cross's denial of reimbursement for the bad debt and charity costs.

The Deputy Administrator of the Health Care Financing Administration, to whom the Secretary's power to review the PRRB's decisions has been delegated, reversed the

Board's findings in regard to the return on equity issue and affirmed the decision to deny reimbursement of bad debt and charity costs.

The hospitals filed suit in district courts for judicial review of this decision....

* * *

(3) Return on Equity Capital

The return on equity issue has been raised in several other courts. The hospitals' basic contention is that they should be reimbursed by the Medicare program for a reasonable rate of return on their net assets used in the treatment of Medicare patients. The plaintiffs rest their argument on the following grounds: (A) the Deputy Administrator had no power to reverse the PRRB's decision to grant these plaintiffs return on equity costs, therefore the PRRB's decision is final, [not at issue on appeal] (B) great deference should be given to PRRB's decision, (C) a return on equity is a "reasonable cost" of providing services under 42 U.S.C. §1395x(v)(1)(A), (D) the denial of reimbursement for these costs constitutes a violation of the just compensation clause of the Fifth Amendment, and (E) since proprietary (for-profit) hospitals are given a return on net assets reimbursement, these plaintiffs, non-proprietary hospitals, are being denied their rights to equal protection.

In order to understand the plaintiffs' arguments, it is necessary to review some background and legislative history of the Medicare program. The terms "return on equity," "return on equity capital," "return on net assets," and "imputed interest" are all used to describe the hospitals' claims of entitlement to reimbursement for the opportunity cost of capital used in the treatment of Medicare patients. Under Part A of the Medicare Act, 42 U.S.C. §§1395c-1395i-2, which provides hospital insurance benefits to qualified elderly and/or disabled recipients, hospitals are reimbursed for the "reasonable cost" of

providing services to these recipients. The thrust of the plaintiffs' position in this case is that a return on equity is a reasonable cost under the Act and should be reimbursed. Title 42 U.S.C. §1395x(v)(1)(A) initially defines reasonable cost, for provider reimbursement purposes, as:

> (v)(1)(A) The reasonable cost of any services shall be the cost actually incurred, excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services, and shall be determined in accordance with regulations establishing the method or methods to be used, and the items to be included, in determining such costs for various types or classes of institutions, agencies, and services;....

The section further provides the following principle which is to be used to determine whether costs are or are not reimbursable reasonable costs:

> Such regulations shall (i) take into account both direct and indirect costs of providers of services... in order that, under the methods of determining costs, the necessary costs of efficiently delivering covered services to individuals covered by the insurance programs established by this subchapter will not be borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne by such insurance programs....

The gist of the "necessary costs" requirement is that hospitals will be reimbursed for costs, either direct or indirect, which are attributable to Medicare patients. The Medicare Program is not to be responsible for costs incurred on behalf of non-Medicare patients. If indirect costs are attributable to both Medicare and non-Medicare patients, the provider will be reimbursed for the proportionate share of such indirect costs as are incurred for the benefits of the Medicare patients. 42 C.F.R. §405.451(b)(1) and (c)(3)

The Secretary of Health and Human Services has the responsibility for administering the Medicare Program. 42

U.S.C. §1395kk. The Secretary is authorized by Congress to "prescribe such regulations as may be necessary to carry out the administration of the insurance programs under this [subchapter]." 42 U.S.C. §1395hh. These regulations are found in the Code of Federal Regulations, Subchapter B, Part 405 of 42 C.F.R. Chapter IV.

The regulations further delineate the types of costs which will be allowable under the Program. These regulations flesh out the general principles laid down in 42 U.S.C. §1395x(v)(1)(A). One regulation which is at issue in this case, at least indirectly, is 42 C.F.R. §405.429, which specifically authorizes a proportionate reimbursement for return on equity in the case of proprietary (for profit) hospitals.

> §405.429 Return on equity capital of proprietary providers.
>
> (a) *Principle.* (1) A reasonable return on equity capital invested and used in the provision of patient care is allowable as an element of the reasonable cost of covered services furnished to beneficiaries by proprietary providers....
>
> (2) For the purposes of this subpart, the term "proprietary providers" is intended to distinguish providers, whether sole proprietorships, partnerships, or corporations, that are organized and operated with the expectation of earning profit for the owners, from other providers that are organized and operated on a nonprofit basis.
>
> (b) *Application*—(1) *Computation of equity capital.* Proprietary providers generally do not receive public contributions and assistance of Federal and other governmental programs in financing capital expenditures. Proprietary institutions historically have financed capital expenditures through funds invested by owners in the expectation of earning a return. A return on investment, therefore, is needed to avoid withdrawal of capital and to attract additional capital needed for expansion....

Presumably for the reasons expressed in subsection (b), above, the Secretary has made no analogous provision for a return on investment costs in the cases of nonproprietary providers. The plaintiffs in this case are challenging the Secretary's disallowance of a proportionate share of their return on equity costs, primarily on the basis of their perception of the general spirit of 42 U.S.C. §1395x(v)(1)(A) and on some legislative history.

The first Medicare Regulations, issued by the Secretary in 1966, authorized a reimbursement of an additional 2% of total allowable costs for nonproprietary facilities as compensation for otherwise unspecified costs. One of the costs included in the 2% was a return on equity captial. (See Proposed HEW Regulations, §§405.402(e) and 405.428(b) (1966); statements of the Commissioner of Social Security, Robert M. Ball in the *Hearings on Reimbursement Guidelines for Medicare Before the Senate Committee on Financing*, 89th Congress, 2d Sess., at 55-56 (1966), R. 0501-2; and Mr. Ball's comments in the *1966 Hearings* at 72 [R. 0508].) Proprietary hospitals were only given a 1-to-1½% additional reimbursement. The regulation expressly recognized that proprietary hospitals had already been given a return on equity capital reimbursement under §1395x(v)(1)(B) and 42 C.F.R. §405.429. 42 C.F.R. §405.428 (formerly 20 C.F.R. §405.428).

It is clear that the nonproprietary providers' 2% allowance did include a return on equity capital: it is equally clear that Congress heard discussion of the return on equity issue before these regulations were passed. The problems at issue for the nonproprietary hospital plaintiffs began in June, 1969, when the Secretary dropped both the 2% and the 1½% allowances. 34 Fed.Reg. 9927 (June 27, 1969). As a result, the nonproprietary providers are left with only the "reasonable cost" definition found in 42 U.S.C. §1395x(v)(1)(A). Proprietary providers may still be reimbursed for return on equity capital costs pursuant to 42 C.F.R. §405.429, the regulatory counterpart of §1395x(v)(1)(A).

The plaintiffs in this case now contend that a return on equity is a "reasonable cost" and that it is anomalous to grant a return on equity capital reimbursement to proprietary but not to nonproprietary providers. The arguments which shore up their contention that Congress intended that all providers be reimbursed for return on equity expenses are based primarily on post-enactment legislative history and on more generalized arguments that this expense is a "reasonable cost" within the meaning of 42 U.S.C. §1395x(v)(1)(A).

* * *

(c) Is a Return on Equity Capital a Reasonable Cost for Nonproprietary Providers Under 42 U.S.C. §1395x(v)(1)(A)?

The stance of the Department of Health and Human Services on this issue is that nonproprietary providers may not recoup any Medicare funds for a return on equity. The rationale of the Deputy Administrator is that there is no regulation that authorizes the reimbursement, so if the hospitals are to recover these amounts, it must be done as a reasonable cost under §1395x(v)(1)(A). The Department's analysis of this statute and its conclusions is set out in the Deputy Administrator's opinion in the group appeal now before the Court:

> It would appear that if a return on equity capital were paid to non-profit hospitals, Medicare would be paying a disproportionate share of provider costs. This is because the return is a profit rather than a cost. Under Section 1861(v)(1)(A) of the Act and the supporting regulations, Medicare reimburses all of a provider's reasonable costs in caring for Medicare beneficiaries. This includes a proportionate share of the cost of capital investment related to patient care such as a building or equipment.
>
> In this case, the Board found that non-profit providers need the funds from the return on equity capital for capital investment purposes, and to cover the costs of bad debts and charity allowances. However, under

these circumstances, Medicare would be paying an amount in excess of its share of reasonable cost. This excess would be used to satisfy the burden of non-Medicare patients. This is contrary to the mandate in Section 1861(v)(1)(A) of the Act and the Board's finding in this regard is clearly erroneous.

Based on the specific wording of Section 1861(v)(1)(B) of the Act and 42 C.F.R. 405.429, and the Congressional comments, the Deputy Administrator finds that a return on equity capital is not an element of reasonable cost for non-profit providers. It is not an out-of-pocket cost and was not the type of cost contemplated as reasonable, either direct or indirect, when Section 1861(v)(1)(A) was enacted. Section 1861(v)(1)(B) was enacted because under Section 1861(v)(1)(A) alone a return on equity capital could not be paid to proprietary providers. Therefore, the Board's reliance on Section 1861(v)(1)(A) in this regard is erroneous.

The Secretary's position in regard to 42 C.F.R. §405.429 (quoted above, concerning return on equity for proprietary hospitals) is correct. The terms of this statute are explicit in the distinction between proprietary and non-proprietary providers insofar as the return on equity issue is concerned. (In accord, *Valley View Community Hospital v. United States*, No. 126-80C (Slip Op., U.S. Court of Claims, May 19, 1982), ¶31,978, CCH Medicare and Medicaid Guide.) The rationale for the distinction expressed in the regulation is that proprietary providers must raise capital through funds invested by owners in the expectation of earning a profit. Alternatively, non-proprietary hospitals have other sources of funding, i.e., public contributions and governmental programs. *Id.* ¶31,978 Medicare and Medicaid Guide, at 9748. The plaintiffs have not brought forward any regulations which affirmatively authorize a return on equity for nonprofit hospitals. They are relegated to the very general reasonable cost standard defined in §1395x(v)(1)(A).

As noted above, the Secretary's position is that the intent of Congress, as set forth in §1395x(v)(1)(A), in light of its legislative history, is that a return on equity is not a reasonable cost. This is also the position of the courts which have viewed this issue.

The legislative history of the return on equity issue has been quoted exhaustively by both parties to this litigation. It has also been summarized in *Hospital Authority of Floyd County, Georgia v. Schweiker*, 522 F. Supp. 569 (ND. Ga. 1981) [, *aff-d*, 707 F.2d 456 (11th Cir. 1983)].

The plaintiffs' argument that a return on equity is a reasonable cost under §1395x(v)(1)(A) is not borne out by the legislative history. The bulk of the plaintiffs' authority is testimony from the transcript of the 1966 Senate Finance Committee hearings on the issue of reimbursement guidelines. These hearings were held nearly a year after the Medicare Act was passed by Congress. "Such post-enactment history is not the surest guide of the legislative intent in initially passing the Act. *Cf. Rogers v. Frito-Lay, Inc.*, 611 F.2d 1074 (5th Cir. 1974) [*cert. den., Moon v. Roadway Express, Inc.*, 449 U.S. 889, 101 S. Ct. 246, 66 L.Ed.2d 115 (1980)]. Nevertheless, the testimony of the witnesses and the remarks of the Senators are quite instructive." *Floyd County, supra*, 522 F. Supp. at [571].

The plaintiffs have placed great stock in statements made by Robert Ball, the Commissioner of Social Security, who agreed with the policy of including a return on equity factor in the 2% allowance, because giving a return on equity solely to proprietary hospitals would foster the "anomalous result" of "reimbursing a profit-making organization more than a nonprofit organization for rendering exactly the same service—solely by reason of allowing return on investment in one case but not the other." *Reimbursement Guidelines for Medicare: Hearing before the Committee on Finance*, United States Senate, 89th Cong., 2d Sess. (Comm. Print, May 25, 1966), at 56

(hereinafter "Hearings"). Mr. Ball and Mr. Willcox, the General Counsel of Social Security agreed that a return on investment was "some bit of this 2% item." *Id.*, at 107. "The Senate Committee, in short, was being told by the Commissioner [Mr. Ball] that no return on equity capital was allowed explicitly, but that a return on equity capital was discreetly included in the 2% allowance." *Floyd County, supra*, at 572.

The idea that even the proponents of a return on equity capital classified it as a portion of the 2% allowance rather than as an automatic "reasonable cost" is significant. Shortly after the hearings Congress amended the Act to provide explicitly for a return on equity to proprietary facilities.Title 42 U.S.C. §1395x(v)(1)(B), the statutory counterpart of 42 C.F.R. §405.429, provides:

> (B) Such regulations in the case of extended care services furnished by proprietary facilities shall include provision for specific recognition of a reasonable return on equity capital, including necessary working capital, invested in the facility and used in the furnishing of such services, in lieu of other allowances to the extent that they reflect similar items [i.e., the 2% allowance]....

Section 1395x(v)(1)(B) and 42 C.F.R. §405.429 remained after the 1969 decision to discontinue the 1½% and 2% allowances. The following lengthly portion of the *Floyd County* analysis of the legislative history reveals that the understanding of the Congress was that a return on equity was not provided in the original Act and that is was not within the ambit of a §1395x(v)(1)(A) reasonable cost:

> Having traced the footprints on the trial of legislative enactment, the Court concludes that it was not the intent of Congress to provide an allowance for a return on equity capital to all facilities. In reading the transcript of the Senate hearing, it is apparent that the Committee basically approved the Secretary's proposal to table the issue of providing such an

allowance. This is what the Health Insurance Benefits Advisory Council recommended, and this recommendation was passed on to the Committee. The decision to amend the Act in October, 1966 to provide for the allowance for proprietary facilities evidences Congressional intent to reverse the former policy of simply obscuring the allowance as a "bit" of the 2% allowance.

The exchanges at the Hearing between various Senators and Mr. Ball and other administrative officials made it quite unequivocal that the Senate Committee members believed that a return on equity capital was not, and should not, be provided. For example:

> THE CHAIRMAN [Sen. Russell B. Long]. But did you have the impression anywhere that the congressional intent was that we should have allowed imputed interest on capital?
>
> MR. MYERS [Chief Actuary, Social Security Administration]. No. In making the cost estimates, I had no thought that that would be done.
>
> THE CHAIRMAN. What we are talking about is an item neither you nor we had any idea of allowing. I never had an idea we were going to allow imputed interest. Nobody, so far as I know, in your Department—did your Department have any idea that we were going to allow imputed interest?
>
> MR. BALL. No, Mr. Chairman. And I think one of the main reasons that the staff resisted the tendency of the Health Insurance Benefits Advisory Council to move to this position was not necessarily on the merits of the economic argument, but the fact that it had not been considered, and that it therefore ought to be postponed. That was the thought there.

* * *

MR. BALL. Senator, I think the language of the law "reasonable cost" is open to a great variety of interpretations. The discussion, the legislative history, the committee report, pinned that down considerably....I was answering literally the question of whether the term "reasonable cost" could have included such things [e.g. return on equity capital].

But I don't think it would have been reasonable to so interpret the term in the light of the discussions and the legislative history.

* * *

SENATOR WILLIAMS. In computing the costs incurred, how can you get an estimate for interest which is not owed, not paid? How can you get an allowance for an interest charge not owed and not paid, if you are going to stick to the formula of actual costs incurred?

MR. BALL. We did not accede to this argument for allowing an interest return on equity capital.

Hearings, 49-51.

MR. COHEN [Under Secretary]. I think the point, Senator, is that Congress did, in setting up the concept of reasonable cost, intend for us to reflect what the economic cost of hospital care was. And as Mr. Gordon says, if you were going to pay for the interest on borrowing the money it seems to us to be reasonable to try to reflect in the cost what is actually the incurred cost of a hospital when it has to operate. So while it was not discussed in those specific terms, I think it is absolutely consistent with the intent of Congress that what the program should pay should really reflect what the economic cost is for a hospital in providing these services.

SENATOR ANDERSON. I just could not disagree with you more. We discussed this over and over

and over agin, and rejected that in the comittee. I just call your attention to the committee report, page 33:

> The cost of hospital services varies widely from one hospital to another, and the variations reflect differences in quality and cost. The same thing is true with respect to the cost of services provided. The provision in this bill for the payment of reasonable cost of services is intended to meet the actual cost.

"Actual." This is not economic or fanciful or anything else. We put it in there so they could not bring in the various things you are talking about now. How do you get around this?

MR. COHEN. Well I think this is the actual cost. I think when you are talking about economic costs—

* * *

SENATOR ANDERSON. Just one more question from page 37 of the report which I think should have some importance to you. I really believe when a committee goes to the extent of preparing a report, and filing it, and telling the Congress and the people that this is what they mean, it is wrong to try to reinterpret it some other way.

> In paying reasonable cost, it should be the policy of the insurance program to so reimburse a hospital or other provider that an accounting may be made at the end of each cost period for costs actually incurred.

Not beneficiarily incurred, or anything else—"actually incurred." And if you don't pay interest on a debt, that is not a cost that it actually incurred.

id. at 69-70.

At the outset of the hearing, Senator Long, the Chairman, outlined the various topics to be discussed:

> Three. Can the reasonable cost include a return on investment for proprietary institutions without a similar payment to the nonprofit facilities. And that is a fair question to be raised. It seems to me that it was intended that there should be a return on investment to proprietary institutions—and that there is no similar requirement that they be made to public or nonprofit groups.

id. at 43.

> In addition, when the Act was amended in October, Congressman John W. Byrnes of Wisconsin stated, ["Under existing law] the amount that will be paid to the individual nursing home or facility—shall be, and I quote, 'the reasonable cost' of furnishing such care. In other words, as the law now stands, fundamentally all the Social Security Administration can pay are the costs, with no allowance for profits or a return on the invested capital." 112 Cong. Rec. 28220 (1966). Senator Long made a similar statement to the Senate, "As the proposed Medicare regulations stood [an investor] would only have been reimbursed for the actual costs of providing services with no specific return given on his investment." 112 Cong. Rec. 27608 (1966).

Floyd County, supra, at 572-74.

This Court concludes, as did the district court for the Northern District of Georgia, id., at 575, that a payment for a return on equity capital is not within the scope of §1395x(v)(1)(A). The plaintiffs have brought forward no cases which stand as authority for the proposition that a return on equity is a §1395x(v)(1)(A) reasonable cost. Rather, they have relied on: (1) the PRRB's decision, (2) general policy statements which assert that a policy of nonreimbursement for nonproprietary providers would violate the mandate of §1395x(v)(1)(A) in that a heavier share of costs would be borne by non-Medicare patients, and (3) analogies to indirect costs which are reimbursed (i.e., straight line depreciation, 42 C.F.R. §405.415, the 1966-1969 2% allowance, 20 C.F.R. §405.428, interest on

some loans, 42 C.F.R. §405.[419], and return on net assets to proprietary hospitals, 42 C.F.R. §405.429).

None of these arguments addresses the critical question: did the Secretary misconstrue the statute in denying a return on equity? Given the legislative history quoted above, it is clear that not only did Congress not consider a return on equity when it passed the Medicare Act, it specifically viewed this item during the 1966 Hearings as an expense which did not fall within the purview of §1395x(v)(1)(A). When the 2% allowance, some "bit" of which was a return on equity, was abandoned in 1969, the expense, as to nonproprietary providers, return to its status as a nonreimbursable expense. In light of its legislative history, 42 U.S.C. §1395x(v)(1)(A) cannot be stretched to cover this item of cost.

Another district court which has considered this issue of whether a return on equity is a reasonable cost was recently upheld by the Court of appeals for the District of Columbia Circuit. *American Medical International, Inc. v. Secretary of Health, Education and Welfare*, 466 F. Supp. 605 (D.D.C. 1979), *aff'd*, 677 F.2d 118 (D.C. App. 1981). In *American Medical International* the court discussed return on equity capital because the plaintiffs had analogized it to the stock maintenance costs for which they sought reimbursement. The district court stated:

> Plaintiffs argue that stock maintenance costs, though related to investment, should be reimbursed because Medicare allows proprietary providers a return on equity capital. 42 U.S.C. §1395x(v)(1)(B). [Footnote omitted.] By allowing this payment, plaintiffs contend, the Medicare program expressly recognized that costs related to investment may be reimbursed. This argument assumes that the return on equity capital in §1395x(v)(1)(B) is a reasonable cost within the meaning of §1395x(v)(1)(A). However, this return on equity provisions was added subsequent to the passage of the Medicare Act and it constitutes the sole exception to the basic Medicare principle that

> reimbursement be limited to those costs actually incurred in providing patient care services. It is clear from the purpose behind the return on equity provision (§1395x(v)(1)(B)), its legislative history, and the provision itself that the return on equity capital provision cannot be used by plaintiffs to support the position that reasonable costs under 42 U.S.C. §1395x(v)(1)(A) was meant to include costs for investment.

Id., 466 f. Supp. at 613. (In accord, *Valley View, supra.*)

Therefore, the Secretary did not misinterpret §1395x(v)(1)(A), nor do the regulations conflict with the statutory scheme. Although the plaintiffs' policy arguments might have been convincing during the initial stages of legislative debate on the Medicare legislation, they were not accepted by Congress. It is beyond the province of the Court to do more than discern the will of Congress on this issue. A return on equity was not within the definition of reasonable cost originally. Since Congress has done nothing to change the statute in the 13 years since the demise of the 2% allowance, this Court cannot proclaim a return on equity capital to be a §1395x(v)(1)(A) reasonable cost.

(d) Does the Statutory or Regulatory Scheme Violate the Just Compensation Provision of the Fifth Amendment?

The plaintiffs contend that if the statutory or regulatory schemes deny a return on equity to nonproprietary providers, they are constitutionally infirm. The hospitals urge that such provisions would violate the Fifth Amendment's mandate that "private property...[not] be taken for public use without just compensation." The plaintiffs have presented the Court with no cases which support this position. They urge that being denied compensation for the opportunity cost of the assets used in furnishing care to Medicare patients is unjust compensation. If the United States does not pay them for the opportunity cost, the plaintiffs claim that the government is not

compensating them sufficiently for property it has taken.

These opportunity cost arguments go to the compensation element and do not need to be answered since the "taking" element of the just compensation clause has not been violated. The plaintiffs have stated that the hospitals are in positions akin to those of public utilities. (Relying on *Smyth v. Ames*, 169 U.S. 466, 18 S. Ct. 418, 42 L.Ed. 819 (1898).) The basic principle of *Smyth*, as stated by the plaintiffs, is that when a business dedicates a portion of its property to activities deemed to be affected with a public interest, the Constitution guarantees that the property will not be used for the public benefit without just compensation being paid for the services rendered.

There has been no taking in this case. The utilities cases relied upon by plaintiffs are analogous to the case at bar, but there are important distinctions which prevent the application of the just compensation clause to this issue. *Smyth* was a case in which the state regulated railroad charges. The parties in *Smyth* were railroads and stockholders of railroads, which were for-profit corporations. The plaintiffs in the instant case are nonprofit hospitals: the payment distinctions on the return on equity issue are made on the basis of the differences between profit-making and nonprofit organizations (see 42 C.F.R. §405.429 and the equal protection discussion below.)

The Court identified as unconstitutional takings of property in which property is "wrested" from its owner for the benefit of another or for the public. *Id.*, 169 U.S. at 524-25, 42 L.Ed. at 841. The prohibition was against "a tariff of rates which is so unreasonable as to practically destroy the value of property of companies engaged in the carrying business...." *Id.*, 169 U.S. at 525, 42 L.Ed. at 841. This "wresting away" and "practically destroying the value of the property" has evolved into a standard which demands at a minimum some loss of use.

The plaintiffs in this case have not demonstrated this type of loss. They have volunteered to participate in the

Medicare program. They can terminate their participation now. They may sell their physical plant at any time.

A district court for the Eastern District of New York recently dealt with the just compensation clause's "taking" requirement in a similar case involving Medicaid reimbursement provisions. *Hempstead General Hospital v. Whalen*, 474 F. Supp. 398 (E.D.N.Y. 1979), *aff'd without opinion*, 622 f.2d 573 (2 Cir. 1980). The plaintiffs in that case challenged federally approved state limitations on capital cost reimbursements to potential purchasers of health care facilities. They contended that these capital reimbursement limitations constituted a taking because they eliminated many potential buyers of health care facilities.The Medicaid regulations at issue limited capital reimbursement of purchasers to the next depreciated value of the property rather than to either the purchase price or the fair market value. After reviewing the recent just compensation cases, the Court held that there was no taking in spite of the fact that there was a greatly lessened market for hospital facilities and the regulations "impose upon plaintiffs a constantly diminishing potential sale price." *Id.*, 474 F. Supp. at 411.

The reasoning of the *Hempstead* court for the finding of no taking is that critical elements of governmental invasion were missing:

> As before, plaintiffs have full right to use the medical center property. The challenged regulations impose no direct legal restraint upon the property or upon its use. There has been no physical entry by the state, no ouster of the owner, no legal interference with plaintiffs' physical use, possession or enjoyment of the medical center, nor any legal interference with the owner's power of disposition of the property.

Id., at 410-11.

The New York court held that the regulations did not constitute a *de facto* taking, which requires a "physical

entry by the condemnor, a physical ouster of the owner, a legal interference with the physical use, possession or enjoyment of the property or a legal interference with the owner's power of disposition of the property." *Id.*, at 410, citing *city of Buffalo v. J.W. Clement Company*, 28 N.Y.2d 241, 253; [321 N.Y.S.2d 345, 357; 269 N.E.2d 895, 903] (1971). Neither did the regulations come within the ambit of the cases which deal with unconstitutional regulation of utilities since the plaintiffs "have not lost any existing right of property or contract." *Hempstead, supra*, at 410. Within the context of the utility overregulation cases, the court set forth the following rule:

> Many kinds of legislative and administrative action affect property values, but, without some diminution in the owner's right of use, do not constitute a taking within the purvue of the Fourteenth Amendment. *Chacon v. Granata*, 515 F.2d 922, 925 (CA5 1975), *cert. denied*, 423 U.S. 930, 96 S. Ct. 279, 46 L.Ed.2d 258 (1975).

Id.

The instant case also lacks elements necessary for a taking. The return on equity rules may not be what the hospitals would design for themselves, but since these plaintiffs retain full rights and control over their net investment, the statutory scheme is not constitutionally deficient.

(d) Does the Statutory or Regulatory Scheme Violate the Equal Protection Clause of the Fifth Amendment?

The plaintiffs claim that the Fifth Amendment is violated if the Medicare statutes and regulations allow or disallow a return on equity solely on the basis of whether a provider is proprietary or nonproprietary. This equal protection argument can only be proved under the Fifth Amendment if the discrimination is "so unjustifiable as to be violative of due process." *Shapiro v. Thompson*, 394 U.S. 618, 642, 89 S. Ct. 1322, 22 L.Ed.2d 600, 619 (1969); *Schneider v. Rusk*, 377 U.S. 163, 168, 84 S. Ct. 1187, 12

L.Ed.2d 218, 222 (1964). Therefore, the due process clause of the Fifth Amendment guarantees equal protection. *United States Department of Agriculture v. Moreno*, 413 U.S. 528, 533 n.5, 93 S.Ct. 2821, 37 L.Ed.2d 782, 787 n.5 (1973).

The plaintiffs have attempted to support its claims that this distinction is discriminatory with statements by Robert Ball (the "anomalous result" testimony from the *Hearings*, quoted above), a 1966 Memorandum of the Comptroller General of the United States in favor of the 2% allowance and unsupported assertions that the distinction between proprietary and nonproprietary providers is neither rational nor reasonable insofar as the return on equity issue is concerned.

The standard to be applied in cases in which the constitutionality of a social welfare program is challenged is the same low level of scrutiny that is applied to legislation regulating business. *Weinberger v. Salfi*, 422 U.S. 749, 771-72, 95 S. Ct. 2457, 45 L.Ed.2d 522, 542-43 (1975). *Salfi* cited with approval social welfare legislation cases (*Richardson v. Belcher*, 404 U.S. 78, 92 S. Ct. 254, 30 L.Ed.2d 231 (1971); *Dandridge v. Williams*, 397 U.S. 471, 90 S. Ct. 1153, 25 L.Ed.2d 491 (1970); and *Flemming v. Nestor*, 363 U.S. 603, 80 S. Ct. 1367, 4 L.Ed.2d 1435 (1960)) which "establish that a statutory classification violates due process only if it is 'patently arbitrary . . ., utterly lacking in rational justification.' 363 U.S. at 611. They establish that a classification violates equal protection only if it lacks a reasonable basis; there is no violation merely because the classification is 'imperfect,' or "'not made with mathematical nicety or because in practice it results in some inequality.'" 397 U.S. at 485-86." *Caylor-Nickel Hospital, Inc. v. Califano*, Civil No. F 77-83 (N.D.Ind. Sept. 10, 1979) ¶30,718, CCH Medicare and Medicaid Guide. In *Caylor-Nickel*, Judge Eschbach, with specific reference to the return on equity provisions, held that the regulations which "provide for profit institution' but not to nonprofit institutions" are

sufficiently rationally based to satisfy *Salfi. Id.*, ¶30,718, Medicare and Medicaid Guide at 9098. The reasons for this finding of sufficient rationality to sustain the constitutionality of the statutory and regulatory scheme are that:

> It is certainly rational that profit institutions receive this advantage when nonprofit institutions receive numerous other advantages, such as various grants and contributions, and tax-exempt status. The purpose and rationality of this classification is made clear in 42 U.S.C. §1395x(v)(1)(A) and in the legislative history.... The distinction drawn between profit and nonprofit institutions violates nothing in the fifth amendment. *See Am. Med. Int'l, Inc. v. Sec. of H.E.W.*, 466 F. Supp. 605, 615 (D.C. Dist. Columb. 1979).

Other cases which have accepted the rationality of the distinction between proprietary and nonproprietary providers in the context of equal protection challenges are *Valley View, supra; Stevens Park Osteopathic Hospital, Inc. v. United States*, 633 F.2d 1373 (Ct.Cl. 1980); and *Floyd County, supra.* Another explanation of the rationality of this distinction, which relies upon the section of Judge Eschbach's opinion quoted above, states:

> Both the Senate Finance Committee staff report and G.A.O. report outline various reasons why profit and nonprofit institutions should be treated differently. Nonprofit institutions have various benefits which are unavailable to proprietary institutions: tax benefits, Hill-Burton grants, charitable donations, and numerous other advantages created by the state and federal governments.

Floyd County, supra, 522 F. Supp. at 575-76.

The plaintiffs have brought forward no cases which refute these findings of rationality. The Court must agree that the distinction between proprietary and nonproprietary providers is rationally based.

All of the plaintiffs' return on equity capital claims fail.

As to these issues, the Court must grant the defendant's motion for summary judgment.

(4) Bad Debts and Charity Costs

The hospitals ask the Court either to declare a regulation with respect to bad debts, charity, and courtesy allowances to be inconsistent with the "reasonable cost" requirement of §1395x(v)(1)(A), or to rule that it violates the due process clause of the Fifth Amendment. The hospitals claim that because bad debts and charity not attributable to Medicare patients are categorized by accountants as economic costs of running a hospital, the Medicare program should reimburse them for a proportionate share of these costs.

The Secretary has great leeway to formulate standards for the determination of which are "reasonable costs" under 42 U.S.C. §1395x(v)(1)(A). In 1966, the Secretary promulgated the following regulation, now challenge by the plaintiffs:

> §405.420 Bad debts, charity, and courtesy allowances.
>
> (a) *Principle.* Bad debts, charity, and courtesy allowances are deductions from revenue and are not to be included in allowable cost; however, bad debts attributable to the deductibles and coinsurance amounts are reimbursable under the program.
>
> (b) *Definitions*—(1) *Bad debts.* Bad debts are amounts considered to be uncollectible from accounts and notes receivable which were created or acquired in providing services. "Accounts receivable" and "notes receivable" are designations for claims arising from the rendering of services, and are collectible in money in the relatively near future.
>
> (2) *Charity allowances.* Charity allowances are reductions in charges made by the provider of services because of the indigence or medical indigence of the patient.
>
> (3) *Courtesy allowances.* Courtesy allowances indicate a reduction in charges in the form of an

allowance to physicians, clergy, members of religious orders, and others as approved by the governing body of the provider [, for services received from the provider]. Employee fringe benefits, such as hospitalization and personnel health programs, are not considered to be courtesy allowances.

(c) *Normal accounting treatment: Reduction in revenue.* Bad debts, charity, and courtesy allowances represent reductions in revenue. The failure to collect charges for services rendered does not add to the cost of providing the services. Such costs have already been incurred in the production of the services.

....

(g) *Charity allowances.* Charity allowances have no relationship to beneficiaries of the health insurance program and are not allowable costs. The cost to the provider of employee fringe-benefit programs is an allowable element of reimbursement.

From the above it will be noted that plaintiffs are specifically allowed to collect every penny of bad debts attributable to the deductibles and coinsurance amounts which Medicare patients fail to pay. In other words, payments are reduced in the first instance by applicable deductibles and coinsurance amounts, 42 U.S.C. §1395e; 42 C.F.R. §405.110(b). Notwithstanding such fact, the amount of these reductions is eventually paid to plaintiffs to the extent that plaintiffs are not otherwise able to collect the same. 42 C.F.R. §405.420(a). Since the exact amount of the bad debts incurred by Medicare patients in the foregoing areas is reimbursed, it is logical to deny reimbursement, either directly or as an item of overhead, of similar losses of revenue attributable to non-Medicare patients, in keeping with the congressional policy as expressed in 42 U.S.C. §1395x(v)(1)(A).

* * *

The Congress has said that costs attributable to non-Medicare patients are not to be borne by the Medicare

program. All of the items excluded by 42 C.F.R. §405.420 (a) are just such costs or, more accurately, lack of revenue. The challenged regulation appears to be in complete harmony with both the letter and the spirit of the statute, and the decision of the Board with respect thereto is correct.

...The final decision of the Secretary is affirmed, and summary judgment will be rendered in favor of the defendants in the consolidated cases.

Dated this 12 day of August, 1982.

/s/ S. HUGH DILLIN

S. Hugh Dillin, Judge.

A true Copy:
Teste:

Clerk of the United States Court of Appeals for the Seventh Circuit

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF INDIANA
INDIANAPOLIS DIVISION

INDIANA HOSPITAL ASSOCIATION, INC.,	
Plaintiff,	
-vs-	NO. IP 76-522-C
RICHARD S. SCHWEIKER, Secretary, Department of Health and Human Services, JOHN A. SVAHN, Commissioner of Social Security,	
Defendants.	
ST. FRANCIS HOSPITAL CENTER,	
THE JOHNSON COUNTY MEMORIAL HOSPITAL,	
THE METHODIST HOSPITAL OF GARY, INC.,	
ST. ELIZABETH HOSPITAL MEDICAL CENTER,	
ST. MARGARET HOSPITAL,	
HENDRICKS COUNTY HOSPITAL,	
LaPORTE HOSPITAL,	
HOWARD COMMUNITY HOSPITAL,	
ST. CATHERINE HOSPITAL OF EAST CHICAGO, INDIANA, INC.,	
CLARK COUNTY MEMORIAL HOSPITAL,	
ST. JOSEPH MEMORIAL HOSPITAL OF KOKOMO, INDIANA, INC.,	
ST. ANTHONY HOSPITAL,	
THE LUTHERAN HOSPITAL OF FORT WAYNE, INDIANA,	
ELKHART GENERAL HOSPITAL,	NO. IP 80-89-C
PARKVIEW MEMORIAL HOSPITAL,	NO. IP 80-206-C
WILLIAM N. WISHARD MEMORIAL HOSPITAL,	NO. IP 80-272-C
GOSHEN GENERAL HOSPITAL,	NO. IP 80-500-C
PUTNAM COUNTY HOSPITAL,	
ST. JOSEPH HOSPITAL OF MISHAWAKA, INDIANA, INC.,	
HENRY COUNTY MEMORIAL HOSPITAL,	
ST. MARY MEDICAL CENTER, INC.,	
PORTER MEMORIAL HOSPITAL,	
WHITE COUNTY MEMORIAL HOSPITAL,	
HANCOCK COUNTY MEMORIAL HOSPITAL,	
MORGAN COUNTY MEMORIAL HOSPITAL,	
GOOD SAMARITAN HOSPITAL,	
CLINTON COUNTY HOSPITAL,	
MEMORIAL HOSPITAL OF FLOYD COUNTY,	
ST. JOSEPH HOSPITAL OF FORT WAYNE, INC.,	
REID MEMORIAL HOSPITAL, INC.,	
DUNN MEMORIAL HOSPITAL,	

SCOTT COUNTY MEMORIAL HOSPITAL,
TIPTON COUNTY MEMORIAL HOSPITAL,
RANDOLPH COUNTY HOSPITAL,
METHODIST HOSPITAL OF INDIANA, INC.,
MEMORIAL HOSPITAL OF SOUTH BEND,
RIVERVIEW HOSPITAL,
DAVIESS COUNTY HOSPITAL,
DECATUR COUNTY MEMORIAL HOSPITAL,
WELLS COMMUNITY HOSPITAL,
JACKSON COUNTY SCHNECK MEMORIAL HOSPITAL,
GREENE COUNTY GENERAL HOSPITAL,
DUKES MEMORIAL HOSPITAL,
THE KING'S DAUGHTERS' HOSPITAL,
PERRY COUNTY MEMORIAL HOSPITAL,
ORANGE COUNTY HOSPITAL,
MEMORIAL HOSPITAL OF LOGANSPORT,
McCRAY MEMORIAL HOSPITAL, INC.,
MARSHALL COUNTY PARKVIEW HOSPITAL,
JASPER COUNTY HOSPITAL,
DEACONESS HOSPITAL, INC.,
DEARBORN COUNTY HOSPITAL,
HUNTINGTON MEMORIAL HOSPITAL,
MERCY HOSPITAL, INC.,
LaGRANGE COUNTY HOSPITAL,
WILLIAM S. MAJOR HOSPITAL,
WASHINGTON COUNTY MEMORIAL HOSPITAL,
WHITLEY COUNTY MEMORIAL HOSPITAL,
STARKE MEMORIAL HOSPITAL,
WHITHAM MEMORIAL HOSPITAL,
WABASH COUNTY HOSPITAL,
ADAMS COUNTY MEMORIAL HOSPITAL,
LAFAYETTE HOME HOSPITAL, INC.,
WOODLAWN HOSPITAL,
BARTHOLOMEW COUNTY HOSPITAL,
COMMUNITY HOSPITAL OF ANDERSON AND MADISON COUNTY, INC.,
BLACKFORD COUNTY HOSPITAL,
BROADWAY METHODIST HOSPITAL,

Plaintiffs

-vs-

RICHARD S. SCHWEIKER, Secretary, Department of Health and Human Services,
PROVIDER REIMBURSEMENT REVIEW BOARD,
THOMAS TIERNEY, Chairman,

Defendants.

JUDGMENT

The Court having this day filed its Memorandum of Decision in the above entitled consolidated causes of action, reading as follows: (H. I.), now therefore,

IT IS CONSIDERED AND ADJUDGED that Cause No. IP 76-522-C is dismissed for lack of jurisdiction over the subject matter of the action.

IT IS FURTHER CONSIDERED AND ADJUDGED that the plaintiffs in Cause Nos. IP 80-89-C, IP 80-206-C, IP 80-272-C, and IP 80-500-C take nothing by their complaints, and summary judgment is hereby entered for the defendants in such actions.

IT IS FINALLY CONSIDERED AND ADJUDGED that plaintiffs pay the costs of these actions.

Dated this 12 day of August, 1982.

/s/ S. HUGH DILLIN

S. Hugh Dillin, Judge

INDIANA HOSPITAL ASSOCIATION, INC.,	
Plaintiff,	
-vs-	NO. IP 76-522-C
RICHARD S. SCHWEIKER, Secretary, Department of Health and Human Services, JOHN A. SVAHN, Commissioner of Social Security,	
Defendants.	
ST. FRANCIS HOSPITAL CENTER, THE JOHNSON COUNTY MEMORIAL HOSPITAL, THE METHODIST HOSPITAL OF GARY, INC., ST. ELIZABETH HOSPITAL MEDICAL CENTER, ST. MARGARET HOSPITAL, HENDRICKS COUNTY HOSPITAL, LaPORTE HOSPITAL, HOWARD COMMUNITY HOSPITAL, ST. CATHERINE HOSPITAL OF EAST CHICAGO, INDIANA, INC., CLARK COUNTY MEMORIAL HOSPITAL, ST. JOSEPH MEMORIAL HOSPITAL OF KOKOMO, INDIANA, INC., ST. ANTHONY HOSPITAL, THE LUTHERAN HOSPITAL OF FORT WAYNE, INDIANA,	
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PUTNAM COUNTY HOSPITAL, ST. JOSEPH HOSPITAL OF MISHAWAKA, INDIANA, INC., HENRY COUNTY MEMORIAL HOSPITAL, ST. MARY MEDICAL CENTER, INC., PORTER MEMORIAL HOSPITAL, WHITE COUNTY MEMORIAL HOSPITAL, HANCOCK COUNTY MEMORIAL HOSPITAL, MORGAN COUNTY MEMORIAL HOSPITAL, GOOD SAMARITAN HOSPITAL, CLINTON COUNTY HOSPITAL, MEMORIAL HOSPITAL OF FLOYD COUNTY, ST. JOSEPH HOSPITAL OF FORT WAYNE, INC., REID MEMORIAL HOSPITAL, INC., DUNN MEMORIAL HOSPITAL.	

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WOODLAWN HOSPITAL,
BARTHOLOMEW COUNTY HOSPITAL,
COMMUNITY HOSPITAL OF ANDERSON AND MADISON COUNTY, INC.,
BLACKFORD COUNTY HOSPITAL,
BROADWAY METHODIST HOSPITAL,

Petitioners

-vs-

RICHARD S. SCHWEIKER, Secretary, Department of Health and Human Services,
PROVIDER REIMBURSEMENT REVIEW BOARD, THOMAS TIERNEY, Chairman,

Defendants.

MEMORANDUM OF DECISION

These cases come before the Court on a variety of motions. The original plaintiff, Indiana Hospital Association, Inc., has moved for partial summary judgment as to Cause No. IP 76-522-C. The defendants have moved to dismiss No. IP 76-522-C, claiming that the Court lacks jurisdiction over the subject matter of that suit. The plaintiffs and the defendants of the four consolidated suits have moved for summary judgment. In accordance with the reasons which follow, the Court will dismiss the Hospital Association suit, No. IP 76-522-C, for lack of subject matter jurisdiction, and enter summary judgment for the defendants on the merits in the four consolidated cases, Nos. IP 80-272-C, IP 80-500-C and IP 76-522-C insofar as it encompasses former Nos. IP 80-89-C and IP 80-206-C.

The facts and legal issues presented by these cases are complex and will be dealth with in greater detail in the body of this memorandum. In brief, these suits present challenges to Medicare reimbursement statutes, regulations and policies by 68 Indiana hospitals and the Indiana Hospital Association, Inc., to which the 68 hospitals belong.

The hospitals claim that they are entitled to reimbursement of the portion of their return on equity capital and bad debt and charity costs that they claim are attributable to the Medicare patients they treat. The Medicare Act was passed in 1965. 42 U.S.C. §§1395, *et seq.* It provides for the reimbursement of the reasonable cost of providing services to Medicare beneficiaries. 42 U.S.C. §1395f(b). The statutory definition of "reasonable cost" is found at 42 U.S.C. §1395x(v)(1)(A). Pursuant to the Medicare Act, the Secretary of Health and Human Services (hereinafter "the Secretary") has promulgated regulations which define the concept of reasonable cost more fully. 42 U.S.C. §1395hh; and 42 C.F.R. §§405.401-405.488.

The 68 plaintiff hospitals have all made claims for reimbursement for return on equity capital and bad debt and

charity costs for a variety of fiscal years with the "fiscal intermediary" which acts as the agent of the Secretary pursuant to 42 C.F.R. §405.651. The fiscal intermediary which rules upon claims made by Indiana hospitals (termed "providers" under the Act) is Mutual Hospital Insurance, Inc. d/b/a/ Blue Cross of Indiana.

These plaintiffs filed claims ("Cost Reports") which Blue Cross. Blue Cross, by "notices of Program Reimbursement" to each of the hospitals, denied payment under the Medicare Act for the return on equity, bad debt and charity claims. The hospitals then pursued the administrative appeals outlined by the Act and the Secretary's regulations. 42 U.S.C. §1395oo(a); and 42 C.F.R. §405.1837. The plaintiffs were granted permission to pursue their appeals as a group appeal, since their claims presented common questions of law.

The first level of appeal was to the Provider Reimbursement Review Board ("PRRB" or "Board" hereafter). The PRRB ruled that the hospitals were entitled to a return on equity, but sustained Blue Cross's denial of reimbursement for the bad debt and charity costs.

The Deputy Administrator of the Health Care Financing Administration, to whom the Secretary's power to review the PRRB's decisions has been delegated, reversed the Board's findings in regard to the return on equity issue and affirmed the decision to deny reimbursement of bad debt and charity costs.

The hospitals filed suit in district courts for judicial review of this decision. The original Hospital Association suit, No. IP 76-522-C, which in essence asks for declaratory and injunctive relief for these same two issues, was in this court. Therefore, the other four cases representing a request for review of the administrative decision were sent to this Court for consolidation. The Court will treat the following major issues in this memorandum: (1) subject matter jurisdiction, (2) venue, (3) return on equity capital, and (4) bad debts and charity.

Discussion

(1) Subject Matter Jurisdiction

The defendants have moved to dismiss IP 76-522-C, the Hospital Association suit, for lack of subject matter jurisdiction. The plaintiff claims that the Court has jurisdiction over this case pursuant to 28 U.S.C. §§1331, 1337, 1361, 2201 and the Administrative Procedure Act, 5 U.S.C. §§701, *et seq.* The defendants in the other cases have not challenged the power of the Court to review the Secretary's decisions under 42 U.S.C. §1395oo(f)(1). Jurisdiction over all of these cases except the Hospital Association suit does lie by virtue of this section, which provides, in pertinent part:

> (f)(1) A decision of the Board shall be final unless the Secretary, on his own motion, and within 60 days after the provider of services is notified of the Board's decision, reverses, affirms, or modifies the Board's decision. Providers shall have the right to obtain judicial review of any final decision of the Board, or of any reversal, affirmance, or modification by the Secretary, by a civil action commencing within 60 days of the date on which notice of any final decision by the Board or of any reversal, affirmance, or modification by the Secretary is received. ...

Therefore, the only question to be determined now is whether the Hospital Association suit, which requests declaratory relief, falls within some jurisdictional grant. This area of federal subject matter jurisdiction has been murky for years, so it is necessary to present a brief historical overview.

Plaintiffs have tried a variety of statutory pathways to get judicial review of decisions made or positions taken by the PRRB or by HHS. Until recently the most successful was 28 U.S.C. §1331. In 1975, however, the Supreme Court announced its decision in *Weinberger v. Salfi*, 422 U.S. 749, 95 S.Ct. 2457, 45 L.Ed.2d 522, which, read with later

interpretive cases, prohibits a finding of jurisdiction over the Hospital Association case.

The critical section discussed in *Salfi, supra*, is §205(h) of the Social Security Act (42 U.S.C. §405(h)), which provides that:

> The findings and decisions of the Secretary after a hearing shall be binding upon all individuals who were parties to such hearing. No findings of fact or decision of the Secretary shall be reviewed by any person, tribunal or governmental agency except as herein provided. No action against the United States, the Secretary, or any officer or employee thereof shall be brought under Section 41 of Title 28 [which includes 28 U.S.C. §1331] to recover on any claim arising under this subchapter.

Section 405(h) is expressly incorporated into the Medicare Act by 42 U.S.C. §1395ii, which states that the section applies to the "same extent" as it is applicable with respect to Title II of the Act.

Salfi dealt with a Social Security benefit entitlement requirement. The Supreme Court held that the language of the third sentence of 42 U.S.C. §405(h) barred §1331 jurisdiction of a constitutional challenge to the Social Security requirement. *See Trinity Memorial Hospital of Cudahy, Inc. v. Associated Hospital Services*, 570 F.2d 660, 664 (7 Cir. 1977). The plaintiffs have attempted to avoid the bar of *Salfi* by stressing the differences between the Social Security and Medicare systems, but the Seventh Circuit has applied *Salfi* expansively in both provider reimbursement disputes *(Trinity, supra)* and to a case of termination of a provider agreement *(Northlake Community Hospital v. United States*, 654 F.2d 1234, 1240 (7 Cir. 1981)).

The most important point decided by the Supreme Court in *Salfi*, for the purposes of this discussion, is "[t]hat the third sentence of §405(h) is more than a codified requirement of administrative exhaustion." *Id.*, 422 U.S. at 757, 45

L.Ed.2d at 534. The Court noted that the "sweeping and direct" language of this third sentence "states that *no* action [Court's emphasis] shall be brought under §1331, not merely that only those actions shall be brought in which administrative remedies have been exhausted." *Id.* According to the Court, the first two sentences of §405(h) require exhaustion of administrative remedies, so the third sentence must mean something more if it is not to be rendered superfluous.

The Supreme Court then stated that the fact that the *Salfi* plaintiffs were raising constitutional issues did not mean that the action did not arise under the Social Security Act. "To contend that such an action does not arise under the Act whose benefits are sought is to ignore both the language and substance of the complaint and judgment." *Id.*, 422 U.S. at 761, 45 L.Ed.2d at 536.

The plaintiff contends that its case should be heard because: (1) it presents constitutional challenges, and/or (2) its claims are outside the scope of *Salfi* because there is no administrative procedure under Medicare comparable to that which exists for challenges to the Social Security program.

The plaintiff insinuates that if the Court does not have jurisdiction over its claims, they will be bereft of judicial review. This position is incorrect. The same legal questions posed in the form of disputed claims for reimbursement (as opposed to this request for equitable relief) are now consolidated with the Hospital Association suit. The plaintiff hospitals in the consolidated suits have presented their arguments to the appropriate officials as they ran the course of prescribed administrative procedure. They have complied with the requirements of *Salfi* and therefore, fall within the jurisdictional grant of 42 U.S.C. §1395oo.

The Seventh Circuit has held that "*Salfi* 'precludes the use of 28 U.S.C. §1331 as a jurisdictional basis' for Medicare provider reimbursement disputes." *Northlake*

Community Hospital v. United States, 654 F.2d 1234, at 1240 (7 Cir. 1981), quoting *Cudahy, supra*. The plaintiff attempts to avoid this ruling by stating that it, as an association of providers, is not a provider per se and therefore, is not subject to the administrative review process. It stresses that it is not seeking to recover on a claim, but is asking for a ruling on the legality of the Act and regulations promulgated thereunder.

This argument, however, is similar to the contention rejected in *Salfi*: it is an attempt to evade the §405(h) ban by recharacterization. In essence, this suit was brought in order to have regulations declared void so that the plaintiff's member hospitals could recover more Medicare expenses. The Hospital Association suit is, in fact if not in form, an action on a claim arising under the Medicare Act and as such, is within the ban of §405(h).

The plaintiff's more substantial argument is that even if §405(h) is applicable, there is still jurisdiction because the Medicare Act contains no provisions for judicial review of the constitutionality of either the statute or of the Secretary's regulations. The plaintiff argues that the Supreme Court surely did not intend that the *Salfi* decision preclude nonstatutory review in cases in which the Act does not provide a review mechanism. In support of its position, the plaintiff points to the *Salfi* Court's treatment of *Johnson v. Robinson*, 415 U.S. 361, 94 S.Ct. 1160, 39 L.Ed.2d 389 (1974).

The Court in *Salfi* noted that in *Johnson* it considered 38 U.S.C. §211(a) which provides:

> [T]he decisions of the [Veterans'] Administration on any question of law or fact under any law administered by the Veterans' Administration providing benefits for veterans...shall be final and conclusive and no other official or any court of the United States shall have power or jurisdiction to review any such decision by an action in the nature of mandamus or otherwise. *Salfi, supra*, 422 U.S. at 761, 45 L.Ed.2d at 536.

The *Johnson* Court found that the provision did not preclude an attack on the constitutionality of a statutory limitation in that such limitation was not a "decision" of the Administrator, but had been made by Congress. The Court found *Salfi* to be inapposite to the *Johnson* case for two main reasons. The Court first observed that the language of §405(h) is quite different in that:

> Its reach is not limited to decisions of the Secretary on issues of law or fact. Rather, it extends to any "action" seeking "to recover on any [Social Security] claim" — irrespective of whether resort to judicial processes is necessitated by discretionary decisions of the Secretary or by his nondiscretionary application of allegedly unconstitutional statutory restrictions. *Salfi, supra*, 422 U.S. at 762, 45 L.Ed.2d at 536.

The Court also found *Johnson* inapposite in that if §211(a) precluded "constitutional challenges to statutory limitations then absolutely no judicial consideration of the issue would be available." The Court continued:

> Not only would such a restriction have been extraordinary, such that "clear and convincing" evidence would be required before we would ascribe such intent to Congress...but it would have raised a serious constitutional question of the validity of the statute as so construed. *Salfi, supra*, 422 U.S. at 762, 45 L.Ed.2d at 537.

The Court noted that this was not a problem in *Salfi* as the Social Security Act, pursuant to §405(g), provided for constitutional challenges to its provisions.

The plaintiff contends that this second difference is a problem in this case as no provision is made in the Medicare Act for judicial review of the constitutionality of the statute or the regulations promulgated thereunder.

In order to be reimbursed, a provider must submit a "cost report" to the fiscal intermediary. If the provider is dissatisfied with the intermediary's award, then it can have a

hearing. The hearing officer, however, must "comply with all the provisions of Title XVIII of the [Medicare] Act and regulations issued thereunder." 20 C.F.R. §405.1829.

Congress also established the PRRB in 1973. The Board has the authority to review many intermediary hearing decisions. 42 U.S.C. §1395oo. It has the power to "affirm, modify or reverse a final determination of the fiscal intermediary with respect to a cost report...." 42 U.S.C. §1395oo(d). The Board, however, is to comply with the Act and regulations issued thereunder. 20 C.F.R. §405.1867.

The PRRB's decision is final unless the Secretary, on his own motion and within 60 days after the provider is notified, "reverses, affirms or modifies the Board's decision." 42 U.S.C. §1395oo(f)(1). The provider then has the right to obtain judicial review of any final decision of the Board or any affirmance, modification or reversal by the Secretary.

The plaintiff argues that since the fiscal intermediary and the Review Board are bound by the Act and the regulations, there is no mechanism for review of its challenge. This contention is analogous to one refuted in *Salfi*.

The administrative process considered by the Supreme Court in *Salfi* was equally incapable of giving the relief requested. *See Aristocrat South, Inc. v. Mathews*, 420 F.Supp. 23 (D.D.C. 1976). Nevertheless, the Supreme Court held that resort to the administrative review process was required and that §405(h) extended to "any 'action' seeking 'to recover on any [Social Security] claim' — irrespective of whether resort to judicial processes is necessitated by discretionary decisions of the Secretary or by his nondiscretionary application of allegedly unconstitutional statutory restrictions." *Id.* 422 U.S. at 762, 45 L.Ed.2d at 536. The First Circuit has noted that the administrative process is not made "inapplicable by reason of a constitutional challenge, beyond the power of the Secretary to take remedial action." *Milo Community Hospital v. Weinberger*, 525 F.2d 144, 147 (1 Cir. 1975).

Remedial action is not even beyond the Secretary's power. The Secretary promulgated these challenged regulations: it is within his competence to provide the relief sought. The Court in *Salfi* stressed the importance of giving the Secretary an opportunity to review the claims made:

> [T]he Social Security Act itself provides jurisdiction for constitutional challenges to its provisions. Thus the plain words of the third sentence of §405(h) do not preclude constitutional challenges. They simply require that they be brought under jurisdictional grants contained in the Act, and thus in conformity with the same standards which are applicable to non-constitutional claims arising under the Act. The result is not only of unquestionable constitutionality, but it is also manifestly reasonable, since it assures the Secretary the opportunity prior to constitutional litigation to ascertain, for example, that the particular claims involved are neither invalid for other reasons nor allowable under other provisions of the Social Security Act.

Id. 422 U.S. at 762, 45 L.Ed.2d at 537. The Medicare Act, pursuant to §1395oo(f)(1), also provides the courts with jurisdiction over constitutional challenges to its provisions. The Secretary must have an opportunity to examine the provisions prior to such judicial review.

The Seventh Circuit discussed *Salfi* and its preclusionary effect in a case involving a constitutional challenge. *Trinity Memorial Hospital v. Associated Hospital Service, Inc.*, 570 F.2d 660 (7 Cir. 1977). It held that 42 U.S.C. §405(h) precluded the use of 28 U.S.C. §1331 as a jurisdictional basis over a due process challenge to a cost accounting hearing procedure. *Id.*, 570 F.2d at 667. The court held, however, that jurisdiction over the constitutional issue would vest in the Court of Claims. *Id.*

Because of §405(h), this Court has no jurisdiction under §1331 to entertain the Hospital Association suit.

The alternative asserted bases for jurisdiction are equally inappropriate for the Hospital Association suit. The Supreme Court has held that 5 U.S.C. §702 (§10(a) of the Administrative Procedure Act) does not represent a grant of jurisdiction. *Califano v. Sanders*, 430 U.S. 99, 97 S.Ct. 980, 51 L.Ed.2d 192 (1977).

Title 28 U.S.C. §2201, the declaratory judgment statute, does not provide the plaintiff with a separate jurisdictional basis. The declaratory judgment provision may not be used to evade a failure of jurisdiction or to avoid exhausting administrative remedies. *Hills v. Eisenhart*, 156 F.Supp. 902 (D. Cal. 1957), *aff'd* 256 F.2d 609 (9 Cir. 1958), *cert. den.* 358 U.S. 832, 79 S.Ct. 53, 3 L.Ed.2d 70 (1958), *reh. den.* 358 U.S. 914, 79 S.Ct. 228, 3 L.Ed.2d 235 (1958).

The allegation that the Court has jurisdiction over this case pursuant to 28 U.S.C. §1337 is wholly unsupported. Section 1337 provides that:

> The district courts shall have original jurisdiction of any civil action or proceedings arising under any Act of Congress regulating commerce or protecting trade and commerce against restraints and monopolies.

Not only is there no authority for the proposition that the Social Security Act regulates commerce, jurisdiction may not be had under §1337 because the plaintiff has not exhausted its administrative remedies.

Mandamus relief under 28 U.S.C. §1361 is similarly unavailable. Mandamus is reserved for extraordinary situations and "lies only to compel the performance of a legal duty which is free from doubt." *Winningham v. HUD*, 512 F.2d 617 (5 Cir. 1975). The "clear, ministerial and nondiscretionary" duty which the plaintiff claims the defendants owe them is to pay the "reasonable cost" of the services which they provide to Medicare patients. Neither the reasonable cost nor the duty to pay is free from doubt, so mandamus would be inappropriate. See *Trinity Memorial, supra*, 570 F.2d at 666, n. 9.

The Hospital Association suit is therefore dismissed for want of subject matter jurisdiction. The other consolidated cases remain for consideration on the merits.

(2) Venue

The defendants have claimed that venue is improper as to the plaintiffs which are located in the Northern District of Indiana. All four of the consolidated areas arose out of the administrative group appeal.

Cases No. IP 80-89-C and IP 80-272-C were filed originally in the Southern District. Cases No. IP 80-206-C and IP 80-500-C are parallel cases to the Southern District suits. They were first filed in the Northern District of Indiana, Hammond Division, as Nos. H 80-77 and H 80-218 and were transferred to this district by Judge McNagney in 1980, pursuant to 28 U.S.C. §1404(a), which provides:

> For the convenience of parties and witnesses, in the interest of justice, a district court may transfer any civil action to any other district or division where it might have been brought.

The question raised by the transfers is whether they are improper because they do not fall within the category of actions which "might have been brought" in the Southern District. The plaintiff list for each of these four cases is identical. Some of the plaintiff hospitals are located in the Northern District, others in the Southern. The defendants contend that claims of the Southern District plaintiffs could not have been brought originally in the Southern District and that therefore the transfers were wrongful. The defendants have moved either to have all four of these cases transferred to the District of Columbia, or for the Northern District plaintiffs' claims (as represented by Nos. IP 80-206-C and IP 80-500-C) to be returned to the Northern District. The defendants base this claim on the venue provision which all parties agree is applicable, 42 U.S.C. §1395oo(f)(1), which states, in pertinent part:

> Such action [to obtain judicial review over decisions by the PRRB or the Secretary] shall be brought in the district court of the United States for the judicial district in which the provider is located or in the District Court for the District of Columbia....

The essence of the defendants' claims is that since some of the plaintiffs are located in the Northern District, they do not meet the requirement of §1395oo(f)(1) that actions must be brought in the "judicial district in which the provider is located." Therefore, they assert that 28 U.S.C. §1404(a), the transfer of venue statute, does not authorize a transfer to this court.

A critical issue which has not been treated by the parties is one of whether, in enacting §1395oo(f)(1), Congress considered the issue of cases which had been consolidated for purposes of the administrative appeals. The defendants, pursuant to the Secretary's regulation 42 C.F.R. §405.1837, allowed these plaintiffs to pursue their claims through the entire administrative process as one case.

Now the government, based upon the venue statutes, asserts that the plaintiffs may not proceeds with their claims in the group which the defendants allowed before.

It is obvious that the Congress, in enacting §1395oo(f)(1), did not anticipate the possibilities of group appeals pursuant to the regulations. 42 C.F.R. §405.1837. Rather than invalidating the regulation which promotes the efficient use of scanty administrative resources in the resolution of disputes of this kind, it is more appropriate for this Court to construe the language of §1395oo(f)(1) to accomplish the result Congress would most likely wish to achieve if it were to consider this problem.

This was a group appeal throughout the administrative appellate process. The same issues are presented now for judicial review. It is most sensible to construe the singular term "provider" in §1395oo(f)(1) loosely, to encompass the entire group. Therefore, since many of the group members

are located in the Southern District, the group could have brought suit here. The transfers of venue under 28 U.S.C. §1404(a) were appropriate.

As a practical matter, it would be a waste of judicial resources to send roughly half of these plaintiffs to the Northern District. The consolidated suit is ripe for a decision on the merits. There is no reason, given chronically crowded court dockets, to have another district court in the Seventh Circuit wrestle with these issues. If an appeal is to be made, the Seventh Circuit can render its decision on the basis of this memorandum of decision. Therefore, the defendants' motions relating to severance and venue are denied.

(3) Return on Equity Capital

The return on equity issue has been raised in several other courts. The hospitals' basic contention is that they should be reimbursed by the Medicare program for a reasonable rate of return on their net assets used in the treatment of Medicare patients. The plaintiffs rest their argument on the following grounds: (A) the Deputy Administrator had no power to reverse the PRRB's decision to grant these plaintiffs return on equity costs, therefore the PRRB's decision is final, (B) great deference should be given to PRRB's decision, (C) a return on equity is a "reasonable cost" of providing services under 42 U.S.C. §1395x(v)(1)(A), (D) the denial of reimbursement for these costs constitutes a violation of the just compensation clause of the Fifth Amendment, and (E) since proprietary (for-profit) hospitals are given a return on net assets reimbursement, these plaintiffs, non-proprietary hospitals, are being denied their rights to equal protection.

In order to understand the plaintiffs' arguments, it is necessary to review some background and legislative history of the Medicare program. The terms "return on equity," "return on equity capital," "return on net assets," and "imputed interest" are all used to describe the

hospitals' claims of entitlement to reimbursement for the opportunity cost of capital used in the treatment of Medicare patients. Under Part A of the Medicare Act, 42 U.S.C. §§1395c-1395i-2, which provides hospital insurance benefits to qualified elderly and/or disabled recipients, hospitals are reimbursed for the "reasonable cost" of providing services to these recipients. The thrust of the plaintiffs' position in this case is that a return on equity is a reasonable cost under the Act and should be reimbursed. Title 42 U.S.C. §1395x(v)(1)(A) initially defines reasonable cost, for provider reimbursement purposes, as:

> (v)(1)(A) The reasonable cost of any services shall be the cost actually incurred, excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services, and shall be determined in accordance with regulations establishing the method or methods to be used, and the items to be included, in determining such costs for various types or classes of institutions, agencies, and services;....

The section further provides the following principle which is to be used to determine whether costs are or are not reimbursable reasonable costs:

> Such regulations shall (i) take into account both direct and indirect costs of providers of services...in order that, under the methods of determining costs, the necessary costs of efficiently delivering covered services to individuals covered by the insurance programs established by this subchapter will not be borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne by such insurance programs....

The gist of the "necessary costs" requirement is that hospitals will be reimbursed for costs, either direct or indirect, which are attributable to Medicare patients. The Medicare Program is not to be responsible for costs incurred on behalf of non-Medicare patients. If indirect costs are attributable to both Medicare and non-Medicare

patients, the provider will be reimbursed for the proportionate share of such indirect costs as are incurred for the benefits of the Medicare patients. 42 C.F.R. §405.451(b)(1) and (c)(3).

The Secretary of Health and Human Services has the responsibility for administering the Medicare Program. 42 U.S.C. §1395kk. The Secretary is authorized by Congress to "prescribe such regulations as may be necessary to carry out the administration of the insurance programs under this title." 42 U.S.C. §1395hh. These regulations are found in the Code of Federal Regulations, Subchapter B, Part 405 of 42 C.F.R. Chapter IV.

The regulations further delineate the types of costs which will be allowable under the Program. These regulations flesh out the general principles laid down in 42 U.S.C. §1395x(v)(1)(A). One regulation which is at issue in this case, at least indirectly, is 42 C.F.R. §405.429, which specifically authorizes a proportionate reimbursement for return on equity in the case of proprietary (for profit) hospitals.

> §405.429 Return on equity capital of proprietary providers.
>
> (a) *Principle.* (1) A reasonable return on equity capital invested and used in the provision of patient care is allowable as an element of the reasonable cost of covered services furnished to beneficiaries by proprietary providers....
>
> (2) For the purposes of this subpart, the term "proprietary providers" is intended to distinguish providers, whether sole proprietorships, partnerships, or corporations, that are organized and operated with the expectation of earning profit for the owners, from other providers that are organized and operated on a nonprofit basis.
>
> (b) *Application*—(1) *Computation of equity capital.* Proprietary providers generally do not receive public contributions and assistance of Federal

> and other governmental programs in financing capital expenditures. Proprietary institutions historically have financed capital expenditures through funds invested by owners in the expectation of earning a return. A return on investment, therefore, is needed to avoid withdrawal of capital and to attract additional capital needed for expansion....

Presumably for the reasons expressed in subsection (b), above, the Secretary has made no analogous provision for a return on investment costs in the cases of nonproprietary providers. The plaintiffs in this case are challenging the Secretary's disallowance of a proportionate share of their return on equity costs, primarily on the basis of their perception of the general spirit of 42 U.S.C. §1395x(v)(1)(A) and on some legislative history.

The first Medicare Regulations, issued by the Secretary in 1966, authorized a reimbursement of an additional 2% of total allowable costs for nonproprietary facilities as compensation for otherwise unspecified costs. One of the costs included in the 2% was a return on equity capital. (See Proposed HEW Regulations, §§ 405.402(e) and 405.428(b) (1966); statements of the Commissioner of Social Security, Robert M. Ball in the *Hearings on Reimbursement Guidelines for Medicare Before the Senate Committee on Financing*, 89th Congress, 2d Sess., at 55-56 (1966), R. 0501-2; and Mr. Ball's comments in the *1966 Hearings* at 72 [R. 0508].) Proprietary hospitals were only given a 1-to-1-1/2% additional reimbursement. The regulation expressly recognized that proprietary hospitals had already been given a return on equity capital reimbursement under §1395x(v)(1)(B) and 42 C.F.R. §405.429. 42 C.F.R. §405.428 (formerly 20 C.F.R. §405.428).

It is clear that the nonproprietary providers' 2% allowance did include a return on equity capital: it is equally clear that Congress heard discussion of the return on equity issue before these regulations were passed. The problems at issue for the nonproprietary hospital plaintiffs

began in June, 1969, when the Secretary dropped both the 2% and the 1-1/2% allowances. 34 Fed.Reg. 9927 (June 27, 1969). As a result, the nonproprietary providers are left with only the "reasonable cost" definition found in 42 U.S.C. §1395x(v)(1)(A). Proprietary providers may still be reimbursed for return on equity capital costs pursuant to 42 C.F.R. §405.429, the regulatory counterpart of §1395x(v)(1)(A).

The plaintiffs in this case now contend that a return on equity is a "reasonable cost" and that it is anomalous to grant a return on equity capital reimbursement to proprietary but not to nonproprietary providers. The arguments which shore up their contention that Congress intended that all providers be reimbursed for return on equity expenses are based primarily on postenactment legislative history and on more generalized arguments that this expense is a "reasonable cost" within the meaning of 42 U.S.C. §1395x(v)(1)(A).

(a) Authority of the Secretary

It is necessary to dispense with two minor arguments made by the plaintiffs before reaching the merits of the return on equity capital issue. The hospitals contend that great deference should be given to the PRRB's decision in favor of the hospitals on the return on equity issue. The decision in favor of the providers was reversed by the Deputy Administrator.

Title 42 U.S.C. §1395oo(f) states that:

> (f) A decision of the Board shall be final unless the Secretary, on his own motion, and within 60 days after the provider of services is notified of the [Provider Reimbursement Review] Board's decision, reverses, affirms or modifies (adversely to such provider) the Board's decision. In any case where such a reversal or modification occurs the provider of services may obtain a review of such decision by a civil action commenced within 60 days of the date he is notified of the Secretary's reversal or modification. Such action

> shall be brought in the district court of the United States for the judicial district in which the provider is located or in the District Court for the District of Columbia....

The Secretary delegated the power to review PRRB decisions to the Administrator of the Health Care Financing Administration, 42 Fed. Reg. 57351 (Nov. 2, 1977). That delegation specifically anticipated the possibility of redelegation, stating that "[t]he authority in Section 1878(f) [42 U.S.C. §1395oo(f)]...may only be redelegated to the Deputy Administrator." On September 5, 1979, the Administrator redelegated his authority to review PRRB decisions to the Deputy Administrator.

The hospitals contend that these delegations were against the will of Congress, since Congress had authorized the Secretary to review the Board's decisions. Therefore, they state, the decision of the PRRB is final and the Court has no jurisdiction over this matter. The cases cited by the plaintiff are not on point.

The usual concern of courts in situations of delegation is that important quasi-judicial final decisions not be made by minor subordinates. This is not the case here. First, it is ludicrous to suppose that the Secretary of Health and Human Services could review all PRRB decisions personally. Second, the Deputy Administrator is not a minor official. Third, the very statute upon which the plaintiffs rely, 42 U.S.C. §1395oo(f), provides for judicial review of the Secretary's decisions.

The Ninth Circuit Court of Appeals has held delegations under HHS's earlier, but analogous, organizational structure to be proper:

> Under the Medicare Act, it is the Secretary who may reverse or modify a decision of the PRRB. 42 U.S.C. §1395oo(f). However, section 8.D of HEW's "Statement of Organization, Functions and Delegations of Authority," 33 Fed.Reg. 5836 (1968), delegates the functions of the Secretary under the Medicare Act to

the Commissioner of Social Security. The District Court correctly found that this was a proper delegation, and was properly exercised in this case.

Pacific Coast Medical Enterprises v. Harris, 633 F.2d 123 (9 Cir. 1980).

The delegations of authority to review PRRB decisions by the Secretary to the Administrator, then to the Deputy Administrator were valid. This Court may review the decision, albeit made by the Deputy Administrator. The reversal of the PRRB must be reviewed as the Secretary's own decision. Not only was the review of the PRRB's decision pursuant to a valid exercise of authority, but the Secretary's decision to deny reimbursement for return on equity must be given a great degree of deference.

(b) Standard of Review

The standard of review of §1395oo(f) decisions is specified to be that established by the Administrative Procedure Act (APA), 5 U.S.C. §§701-706. Section 706 of the APA provides that "the reviewing court shall decide all relevant questions of law, [and] interpret constitutional and statutory provisions," and that the court "hold unlawful and set aside agency action, findings and conclusions found to be...arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law;..." 5 U.S.C. §706.

This "arbitrary, capricious, abuse of discretion" standard is not the equivalent of a de novo review. A recent Ninth Circuit case dealt with the nature of judicial review of a decision by the Secretary of Health, Education and Welfare in the context of a Medicare reimbursement dispute. The Secretary's decision interpreted the reasonable return on equity regulation, 42 C.F.R. §405.429. *Pacific Coast Medical Enterprises v. Harris*, 633 F.2d 123 (9 Cir. 1980). The court, after setting out the standard of review contained in the APA (5 U.S.C. §706, above), stated:

> The primary question before us is whether the Secretary may interpret and apply the Medicare regulations above as he has done in denying PCME's claims. [Footnote omitted.] Generally, when a meaning of a provision within the expertise of an agency is involved, the courts will afford deference to that agency's construction. In such cases, the agency's expertise make [sic] it particularly suited to interpret the language. This is especially true when an agency's own regulation is involved, and ordinarily its construction will be affirmed if it is not clearly erroneous or inconsistent with the regulation. [Citations omitted.]
>
> The deference which a reviewing court is to afford to an agency's interpretation of its regulations is not total, however.... As where courts review an agency's construction of a statute which the agency administers, "the deference owed to an expert tribunal cannot be allowed to slip into a judicial inertia...." [Citations omitted.] Even though the Medicare reimbursement area is complex, and to a great degree left to the Secretary to structure, [footnote omitted] his interpretations are nonetheless subject to our examination.

Id. at 130-31.

The Court in this instance must give deference to the way in which the Secretary interprets his own regulations. However, there is no obligation for the Court to defer to the agency in such matters as challenges to the constitutionality of the Medicare regulatory or statutory scheme. If, for example, a regulation or a construction thereof conflicts with the authorizing congressional statutes or policies underlying those statutes, deference to the Secretary's opinion comes to a halt. *Id.*, at 131-32. The same APA standard of review applies to judicial review of decisions of the PRRB. *Good Samaritan Hospital, Corvallis v. Mathews*, 609 F.2d 949, 951 (9 Cir. 1979).

The plaintiffs have suggested that the ordinary degree of

deference to the Secretary's expertise be lessened in this case because the Secretary reversed the PRRB on the issue of return on equity capital. The government has pointed out that the PRRB now has decided to follow the Secretary's position on the return on equity issue. At this point in the proceedings it does not matter what the PRRB has done.

The Secretary has ultimate responsibility and decision-making authority over the Medicare program. It is his decision (the Deputy Administrator's) that the Court is called upon to review. As noted in *American Medical International, Inc. v. Secretary of Health, Education and Welfare*, 466 F.Supp. 605 (D.D C. 1979), another Medicare reimbursement case:

> Plaintiffs, however, suggest that this Court deviate from the normal rule of deference in this case because the decision of the Provider Reimbursement Review Board differed in substantial part from the Secretary's final decision. As noted, review by this Court shall be "pursuant to the applicable provisions [of the Administrative Procedure Act]." 42 U.S.C. §1395oo(f). [Footnote omitted.] It is well settled that, under the APA, final responsibility for rendering the decision lies in the agency itself, not in any subordinate hearing officers. This is because it is the agency, not any subordinate officers such as the Provider Reimbursement Review Board, that is charged with the responsibility for implementing and administering the agency's program.

Id., 466 F.Supp. at 611. In essence, once the Secretary, or in this case the Deputy Administrator of the Health Care financing Administration, makes his decision, it is immaterial what the PRRB did. This Court is reviewing, in accordance with APA guidelines, the decision of the Secretary.

(c) Is a Return on Equity Capital a Reasonable Cost for Nonproprietary Providers Under 42 U.S.C. §1395x(v)(1)(A)?

The stance of the Department of Health and Human Ser-

vices on this issue is that nonproprietary providers may not recoup any Medicare funds for a return on equity. The rationale of the Deputy Administrator is that there is no regulation that authorizes the reimbursement, so if the hospitals are to recover these amounts, it must be done as a reasonable cost under §1395x(v)(1)(A). The Department's analysis of this statute and its conclusions is set out in the Deputy Administrator's opinion in the group appeal now before the Court:

> It would appear that if a return on equity capital were paid to non-profit hospitals, Medicare would be paying a disproportionate share of provider costs. This is because the return is a profit rather than a cost. Under Section 1861(v)(1)(A) of the Act and the supporting regulations, Medicare reimburses all of a provider's reasonable costs in caring for Medicare beneficiaries. This includes a proportionate share of the cost of capital investment related to patient care such as a building or equipment.
>
> In this case, the Board found that non-profit providers need the funds from the return on equity capital for capital investment purposes, and to cover the costs of bad debts and charity allowances. However, under these circumstances, Medicare would be paying an amount in excess of its share of reasonable cost. This excess would be used to satisfy the burden of non-Medicare patients. This is contrary to the mandate in Section 1861(v)(1)(A) of the Act and the Board's finding in this regard is clearly erroneous.
>
> Based on the specific wording of Section 1861(v)(1)(B) of the Act and 42 CFR 405.429, and the Congressional comments, the Deputy Administrator finds that a return on equity capital is not an element of reasonable cost for non-profit providers. It is not an out-of-pocket cost and was not the type of cost contemplated as reasonable, either direct or indirect, when Section 1861(v)(1)(A) was enacted. Section 1861(v)(1)(B) was enacted because under Section 1861(v)(1)(A) alone a return on equity capital could not be paid to

proprietary providers. Therefore, the Board's reliance on Section 1861(v)(1)(A) in this regard is erroneous.

The Secretary's position in regard to 42 C.F.R. §405.429 (quoted above, concerning return on equity for proprietary hospitals) is correct. The terms of this statute are explicit in the distinction between proprietary and nonproprietary providers insofar as the return on equity issue is concerned. (In accord, *Valley View Community Hospital v. United States*, No. 126-80C (Slip Op., U.S. Court of Claims, May 19, 1982), ¶31,978, CCH Medicare and Medicaid Guide.) The rationale for the distinction expressed in the regulation is that proprietary providers must raise capital through funds invested by owners in the expectation of earning a profit. Alternatively, nonproprietary hospitals have other sources of funding, i.e., public contributions and governmental programs. *Id.*, ¶31,978 Medicare and Medicaid Guide, at 9748. The plaintiffs have not brought forward any regulations which affirmatively authorize a return on equity for nonprofit hospitals. They are relegated to the very general reasonable cost standard defined in §1395x(v)(1)(A).

As noted above, the Secretary's position is that the intent of Congress, as set forth in §1395x(v)(1)(A), in light of its legislative history, is that a return on equity is not a reasonable cost. This is also the position of the courts which have viewed this issue.

The legislative history of the return on equity issue has been quoted exhaustively by both parties to this litigation. It has also been summarized in *Hospital Authority of Floyd County, Georgia v. Schweiker*, 522 F.Supp. 569 (N.D.Ga. 1981).

The plaintiffs' argument that a return on equity is a reasonable cost under §1395x(v)(1)(A) is not borne out by the legislative history. The bulk of the plaintiffs' authority is testimony from the transcript of the 1966 Senate Finance Committee hearings on the issue of reimbursement guidelines. These hearings were held nearly a year after the

Medicare Act was passed by Congress. "Such post-enactment history is not the surest guide of the legislative intent in initially passing the Act. *Cf Rogers v. Frito-Lay, Inc.*, 611 F.2d 1074 (5th Cir. 1974) [*cert. den. Moon v. Roadway Express, Inc.*, 449 U.S. 889, 101 S.Ct. 246, 66 L.Ed.2d 115 (1980)]. Nevertheless, the testimony of the witnesses and the remarks of the Senators are quite instructive." *Floyd County, supra*, 522 F.Supp. at 569.

The plaintiffs have placed great stock in statements made by Robert Ball, the Commissioner of Social Security, who agreed with the policy of including a return on equity factor in the 2% allowance, because giving a return on equity solely to proprietary hospitals would foster the "anomalous result" of "reimbursing a profitmaking organization more than a nonprofit organization for rendering exactly the same service—solely by reason of allowing return on investment in one case but not the other." *Reimbursement Guidelines for Medicare: Hearing before the Committee on Finance*, United States Senate, 89th Cong., 2d Sess. (Comm. Print, May 25, 1966), at 56 (hereinafter "Hearings"). Mr. Ball and Mr. Willcox, the General Counsel of Social Security agreed that a return on investment was "some bit of this 2% item." *Id.*, at 107. "The Senate Committee, in short, was being told by the Commissioner [Mr. Ball] that no return on equity capital was allowed explicitly, but that a return on equity capital was discreetly included in the 2% allowance." *Floyd County, supra*, at 572.

The idea that even the proponents of a return on equity capital classified it as a portion of the 2% allowance rather than as a automatic "reasonable cost" is significant. Shortly after the hearings Congress amended the Act to provide explicitly for a return on equity to proprietary facilities. Title 42 U.S.C. §1395x(v)(1)(B), the statutory counterpart of 42 C.F.R. §405.429, provides:

> (B) Such regulations in the case of extended care services furnished by proprietary facilities shall include provision for specific recognition of a reason-

able return on equity capital, including necessary working capital, invested in the facility and used in the furnishing of such services, in lieu of other allowances to the extent that they reflect similar items [i.e., the 2% allowance]. . . .

Section 1395x(v)(1)(B) and 42 C.F.R. §405.429 remained after the 1969 decision to discontinue the 1-1/2% and 2% allowances. The following lengthy portion of the *Floyd County* analysis of the legislative history reveals that the understanding of the Congress was that a return on equity was not provided in the original Act and that it was not within the ambit of a §1395x(v)(1)(A) reasonable cost:

> Having traced the footprints on the trail of legislative enactment, the Court concludes that it was not the intent of Congress to provide an allowance for a return on equity capital to all facilities. In reading the transcript of the Senate hearing, it is apparent that the Committee basically approved the Secretary's proposal to table the issue of providing such an allowance. This is what the Health Insurance Benefits Advisory Council recommended, and this recommendation was passed on to the Committee. The decision to amend the Act in October, 1966 to provide for the allowance for proprietary facilities evidences Congressional intent to reverse the former policy of simply obscuring the allowance as a "bit" of the 2% allowance.
>
> The exchanges at the Hearing between various Senators and Mr. Ball and other administrative officials make it quite unequivocal that the Senate Committee members believed that a return on equity capital was not, and should not, be provided. For example:
>
> > THE CHAIRMAN [Sen. Russell B. Long]. But did you have the impression anywhere that the congressional intent was that we should have allowed imputed interest on capital?
> >
> > MR. MYERS [Chief Actuary, Social Security Ad-

ministration]. No. In making the cost estimates, I had no thought that that would be done.

THE CHAIRMAN. What we are talking about is an item neither you nor we had any idea of allowing. I never had an idea we were going to allow imputed interest. Nobody, so far as I know, in your Department—did your Department have any idea that we were going to allow imputed interest?

MR. BALL. No, Mr. Chairman. And I think one of the main reasons that the staff resisted the tendency of the Health Insurance Benefits Advisory Council to move to this position was not necessarily on the merits of the economic argument, but the fact that it had not been considered, and that it therefore ought to be postponed. That was the thought there.

* * *

MR. BALL. Senator, I think the language of the law "reasonable cost" is open to a great variety of interpretations. The discussion, the legislative history, the committee report, pinned that down considerably.... I was answering literally the question of whether the term "reasonable cost" could have included such things [e.g. return on equity capital].

But I don't think it would have been reasonable to so interpret the term in the light of the discussions and the legislative history.

* * *

SENATOR WILLIAMS. In computing the costs incurred, how can you get an estimate for interest which is not owed, not paid? How can you get an allowance for an interest charge not owed and not paid, if you are going to stick to the formula of actual costs incurred?

MR. BALL. We did not accede to this argument for allowing an interest return on equity capital.

Hearings, 49-51.

MR. COHEN [Under Secretary]. I think the point, Senator, is that Congress did, in setting up the concept of reasonable cost, intend for us to reflect what the economic cost of hospital care was. And as Mr. Gordon says, if you were going to pay for the interest on borrowing the money it seems to us to be reasonable to try to reflect in the cost what is actually the incurred cost of a hospital when it has to operate. So while it was not discussed in those specific terms, I think it is absolutely consistent with the intent of Congress that what the program should pay should really reflect what the economic cost is for a hospital in providing these services.

SENATOR ANDERSON. I just could not disagree with you more. We discussed this over and over and over again, and rejected that in the committee. I just call your attention to the committee report, page 33:

> The cost of the hospital services varies widely from one hospital to another, and the variations reflect differences in quality and cost. The same thing is true with respect to the cost of services provided. The provision in this bill for the payment of reasonable cost of services is intended to meet the actual cost.

"Actual." This is not economic or fanciful or anything else. We put it in there so they could not bring in the various things you are talking about now. How do you get around this?

MR. COHEN. Well I think this is the actual cost. I think when you are talking about economic costs—

* * *

SENATOR ANDERSON. Just one more question from page 37 of the report which I think should have some importance to you. I really believe when a committee goes to the extent of preparing a report, and filing it, and telling the Congress

and the people that this is what they mean, it is wrong to try to reinterpret it some other way.

> In paying reasonable cost, it should be the policy of the insurance program to so reimburse a hospital or other provider that an accounting may be made at the end of each cost period for costs actually incurred.

Not beneficiarily incurred, or anything else—"actually incurred." And if you don't pay interest on a debt, that is not a cost that it actually incurred.

id. at 69-70.

At the outset of the hearing, Senator Long, the Chairman, outlined the various topics to be discussed:

> Three. Can the reasonable cost include a return on investment for proprietary institutions without a similar payment to the nonprofit facilities. And that is a fair question to be raised. It seems to me that it was intended that there should be a return on investment to proprietary institutions—and that there is no similar requirement that they be made to public or nonprofit groups.

id. at 43.

In addition, when the Act was amended in October, Congressman John W. Byrnes of Wisconsin stated, "[Under existing law] the amount that will be paid to the individual nursing home or facility—shall be, and I quote, 'the reasonable cost' of furnishing such care. In other words, as the law now stands, fundamentally all the Social Security Administration can pay are the costs, with no allowance for profits or a return on the invested capital." 112 Cong. Rec. 28220 (1966). Senator Long made a similar statement to the Senate, "As the proposed Medicare regulations stood [an investor] would only have been reimbursed for the actual costs of providing services with no specific return given on his investment." 112 Cong. Rec. 27608 (1966).

Floyd County, supra, at 572-74.

This Court concludes, as did the district court for the Northern District of Georgia, *id.*, at 575, that a payment for a return on equity capital is not within the scope of §1395x(v)(1)(A). The plaintiffs have brought forward no cases which stand as authority for the proposition that a return on equity is a §1395x(v)(1)(A) reasonable cost. Rather, they have relied on: (1) the PRRB's decision, (2) general policy statements which assert that a policy of nonreimbursement for nonproprietary providers would violate the mandate of §1395x(v)(1)(A) in that a heavier share of costs would be borne by non-Medicare patients, and (3) analogies to indirect costs which are reimbursed (i.e., straight line depreciation, 42 C.F.R. §405.415, the 1966-1969 2% allowance, 20 C.F.R. §405.428, interest on some loans, 42 C.F.R. §405.417(c)(2), and return on net assets to proprietary hospitals, 42 C.F.R. §405.429).

None of these arguments addresses the critical question: did the Secretary misconstrue the statute in denying a return on equity? Given the legislative history quoted above, it is clear that not only did Congress not consider a return on equity when it passed the Medicare Act, it specifically viewed this item during the 1966 Hearings as an expense which did not fall within the purview of §1395x(v)(1)(A). When the 2% allowance, some "bit" of which was a return on equity, was abandoned in 1969, the expense, as to nonproprietary providers, returned to its status as a nonreimbursable expense. In light of its legislative history, 42 U.S.C. §1395x(v)(1)(A) cannot be stretched to cover this item of cost.

Another district court which has considered this issue of whether a return on equity is a reasonable cost was recently upheld by the Court of appeals for the District of Columbia Circuit. *American Medical International, Inc. v. Secretary of Health, Education and Welfare*, 466 F. Supp. 605 (D.D.C. 1979), *aff'd*, 677 F.2d 118 (D.C. App. 1981). In *American Medical International* the court discussed return on equity capital because the plaintiffs had

analogized it to the stock maintenance costs for which they sought reimbursement. The district court stated:

> Plaintiffs argue that stock maintenance costs, though related to investment, should be reimbursed because Medicare allows proprietary providers a return on equity capital. 42 U.S.C. §1395x(v)(1)(B). [Footnote omitted.] By allowing this payment, plaintiffs contend, the Medicare program expressly recognized that costs related to investment may be reimbursed. This argument assumes that the return on equity capital in §1395x(v)(1)(B) is a reasonable cost within the meaning of §1395x(v)(1)(A). However, this return on equity provision was added subsequent to the passage of the Medicare Act and it constitutes the sole exception to the basic Medicare principle that reimbursement be limited to those costs actually incurred in providing patient care services. It is clear from the purpose behind the return on equity provision (§1395x(v)(1)(B)), its legislative history, and the provision itself that the return on equity capital provision cannot be used by plaintiffs to support the position that reasonable costs under 42 U.S.C. §1395x(v)(1)(A) was meant to include costs for investment.

Id., 466 F. Supp. at 613. (In accord, *Valley View, supra.*)

Therefore, the Secretary did not misinterpret §1395x(v)(1)(A), nor do the regulations conflict with the statutory scheme. Although the plaintiffs' policy arguments might have been convincing during the initial stages of legislative debate on the Medicare legislation, they were not accepted by Congress. It is beyond the province of the Court to do more than discern the will of Congress on this issue. A return on equity was not within the definition of reasonable cost originally. Since Congress has done nothing to change the statute in the 13 years since the demise of the 2% allowance, this Court cannot proclaim a return on equity capital to be a §1395x(v)(1)(A) reasonable cost.

(d) Does the Statutory or Regulatory Scheme Violate the Just Compensation Provision of the Fifth Amendment?

The plaintiffs content that if the statutory or regulatory schemes deny a return on equity to nonproprietary providers, they are constitutionally infirm. The hospitals urge that such provisions would violate the Fifth Amendment's mandate that "private property...[not] be taken for public use without just compensation." The plaintiffs have presented the Court with no cases which support this position. They urge that being denied compensation for the opportunity cost of the assets used in furnishing care to Medicare patients is unjust compensation. If the United States does not pay them for the opportunity cost, the plaintiffs claim that the government is not compensating them sufficiently for property it has taken.

These opportunity cost arguments go to the compensation element and do not need to be answered since the "taking" element of the just compensation clause has not been violated. The plaintiffs have stated that the hospitals are in positions akin to those of public utilities. (Relying on *Smyth v. Ames*, 169 U.S. 466, 18 S. Ct. 418, 42 L.Ed. 819 (1898).) The basic principle of *Smyth*, as stated by the plaintiffs, is that when a business dedicates a portion of its property to activities deemed to be affected with a public interest, the Constitution guarantees that the property will not be used for the public benefit without just compensation being paid for the services rendered.

There has been no taking in this case. The utilities cases relied upon by plaintiffs are analogous to the case at bar, but there are important distinctions which prevent the application of the just compensation clause to this issue. *Smyth* was a case in which the state regulated railroad charges. The parties in *Smyth* were railroads and stockholders of railroads, which were for-profit corporations. The plaintiffs in the instant case are nonprofit hospitals: the payment distinctions on the return on equity issue are made on the basis of the differences

between profit-making and nonprofit organizations (see 42 C.F.R. §405.429 and the equal protection discussion below.)

The Court identified as unconstitutional takings of property in which property is "wrested" from its owner for the benefit of another or for the public. *Id.*, 169 U.S. at 524-25, 42 L.Ed. at 841. The prohibition was against "a tariff of rates which is so unreasonable as to practically destroy the value of property of companies engaged in the carrying business...." *Id.*, 169 U.S. at 525, 42 L.Ed. at 841. This "wresting away" and "practically destroying the value of the property" has evolved into a standard which demands at a minimum some loss of use.

The plaintiffs in this case have not demonstrated this type of loss. They have volunteered to participate in the Medicare program. They can terminate their participation now. They may sell their physical plant at any time.

A district court for the Eastern District of New York recently dealt with the just compensation clause's "taking" requirement in a similar case involving Medicaid reimbursement provisions. *Hempstead General Hospital v. Whalen*, 474 F. Supp. 398 (E.D.N.Y. 1979), *aff'd* without opinion, 622 F.2d 573 (2 Cir. 1980). The plaintiffs in that case challenged federally approved state limitations on capital cost reimbursements to potential purchasers of health care facilities. They contended that these capital reimbursement limitations constituted a taking because they eliminated many potential buyers of health care facilities. The Medicaid regulations at issue limited capital reimbursement of purchasers to the net depreciated value of the property rather than to either the purchase price or the fair market value. After reviewing the recent just compensation cases, the Court held that there was no taking in spite of the fact that there was a greatly lessened market for hospital facilities and the regulations "impose upon plaintiffs a constantly diminishing potential sale price." *Id.*, 474 F. Supp. at 411.

The reasoning of the *Hempstead* court for the finding of

no taking is that critical elements of governmental invasion were missing:

> As before, plaintiffs have full right to use the medical center property. The challenged regulations impose no direct legal restraint upon the property or upon its use. There has been no physical entry by the state, no ouster of the owner, no legal interference with plaintiffs' physical use, possession or enjoyment of the medical center, nor any legal interference with the owner's power of disposition of the property.

Id., at 410-11.

The New York court held that the regulations did not constitute a *de facto* taking, which requires a "physical entry by the condemnor, a physical ouster of the owner, a legal interference with the physical use, possession or enjoyment of the property or a legal interference with the owner's property of disposition of the property." *Id.*, at 410, citing *City of Buffalo v. J. W. Clement Company*, 28 N.Y.2d 241, 253; [321 N.Y.S. 345, 356; 269 N.E.2d 895, 902] (1971). Neither did the regulations come within the ambit of the cases which deal with unconstitutional regulation of utilities since the plaintiffs "have not lost any existing right of property or contract." *Hempstead, supra*, at 410. Within the context of the utility overregulation cases, the court set forth the following rule:

> Many kinds of legislative and administrative action affect property values, but, without some diminution in the owner's right of use, do not constitute a taking within the purvue of the Fourteenth Amendment. *Chacon v. Granata*, 515 F.2d 922, 925 (CA5 1975), *cert. denied*, 423 U.S. 930, 96 S. Ct. 279, 46 L.Ed.2d 258 (1975).

Id.

The instant case also lacks elements necessary for a taking. The return on equity rules may not be what the hospitals would design for themselves, but since these plaintiffs retain full rights and control over their net

investment, the statutory scheme is not constitutionally deficient.

(d) Does the Statutory or Regulatory Scheme Violate the Equal Protection Clause of the Fifth Amendment?

The plaintiffs claim that the Fifth Amendment is violated if the Medicare statutes and regulations allow or disallow a return on equity solely on the basis of whether a provider is proprietary or nonproprietary. This equal protection argument can only be proved under the Fifth Amendment if the discrimination is "so unjustifiable as to be violative of due process." *Shapiro v. Thompson*, 394 U.S. 618, 642, 89 S. Ct. 1322, 22 L.Ed.2d 600, 619 (1969); *Schneider v. Rusk*, 377 U.S. 163, 168, 84 S. Ct. 1187, 12 L.Ed.2d 218, 222 (1964). Therefore, the due process clause of the Fifth Amendment guarantees equal protection. *United States Department of Agriculture v. Moreno*, 413 U.S. 528, 533 n.5, 93 S.Ct. 2821, 37 L.Ed.2d 782, 787 n.5 (1973).

The plaintiffs have attempted to support its claims that this distinction is discriminatory with statements by Robert Ball (the "anomalous result" testimony from the *Hearings*, quoted above), a 1966 Memorandum of the Comptroller General of the United States in favor of the 2% allowance and unsupported assertions that the distinction between proprietary and nonproprietary providers is neither rational nor reasonable insofar as the return on equity issue is concerned.

The standard to be applied in cases in which the constitutionality of a social welfare program is challenged is the same low level of scrutiny that is applied to legislation regulating business. *Weinberger v. Salfi*, 422 U.S. 749, 771-72, 95 S. Ct. 2457, 45 L.Ed.2d 522, 542-43 (1975). *Salfi* cited with approval social welfare legislation cases *(Richardson v. Belcher*, 404 U.S. 78, 92 S. Ct. 254, 30 L.Ed.2d 231 (1971); *Dandridge v. Williams*, 397 U.S. 471, 90 S. Ct. 1153, 25 L.Ed.2d 491 (1970); and *Flemming v. Nestor*, 363 U.S. 603, 80 S. Ct. 1367, 4 L.Ed.2d 1435 (1960)) which "establish that

a statutory classification violates due process only if it is 'patently arbitrary . . ., utterly lacking in rational justification.' 363 U.S. at 611. They establish that a classification violates equal protection only if it lacks a reasonable basis: there is no violation merely because the classification is 'imperfect,' or "'not made with mathematical nicety or because in practice it results in some inequality.'" 397 U.S. at 485-86." *Caylor-Nickel Hospital, Inc. v. Califano*, Civil No. F 77-83 (N.D.Ind. Sept. 10, 1979) ¶30,718, CCH Medicare and Medicaid Guide. In *Caylor-Nickel*, Judge Eschbach, with specific reference to the return on equity provisions, held that the regulations which "provide for profit institutions but not to nonprofit institutions" are sufficiently rationally based to satisfy *Salfi*. *Id.*, ¶30,718, Medicare and Medicaid Guide at 9098. The reasons for this finding of sufficient rationality to sustain the constitutionality of the statutory and regulatory scheme are that:

> It is certainly rational that profit institutions receive this advantage when nonprofit institutions receive numerous other advantages, such as various grants and contributions, and tax-exempt status. The purpose and rationality of this classification is made clear in 42 U.S.C. §1395x(v)(1)(A) and in the legislative history. . . . The distinction drawn between profit and nonprofit institutions violates nothing in the fifth amendment. *See Am. Med. Int'l, Inc. v. Sec. of H.E.W.*, 466 F. Supp. 605, 615 (D.C. Dist. Columb. 1979).

Other cases which have accepted the rationality of the distinction between proprietary and nonproprietary providers in the context of equal protection challenges are *Valley View, supra; Stevens Park Osteopathic Hospital, Inc. v. United States*, 633 F.2d 1373 (Ct.Cl. 1980); and *Floyd County, supra*. Another explanation of the rationality of this distinction, which relies upon the section of Judge Eschbach's opinion quoted above, states:

> Both the Senate Finance Committee staff report and G.A.O. report outline various reasons why profit and nonprofit institutions should be treated differently.

> Nonprofit institutions have various benefits which are unavailable to proprietary institutions: tax benefits, Hill-Burton grants, charitable donations, and numerous other advantages created by the state and federal governments.

Floyd County, supra, 522 F. Supp. at 575-76.

The plaintiffs have brought forward no cases which refute these findings of rationality. The Court must agree that the distinction between proprietary and non-proprietary providers is rationally based.

All of the plaintiffs' return on equity capital claims fail. As to these issues, the Court must grant the defendant's motion for summary judgment.

(4) Bad Debts and Charity Costs

The hospitals ask the Court either to declare a regulation with respect to bad debts, charity, and courtesy allowances to be inconsistent with the "reasonable cost" requirement of §1395x(v)(1)(A), or to rule that it violates the due process clause of the Fifth Amendment. The hospitals claim that because bad debts and charity not attributable to Medicare patients are categorized by accountants as economic costs of running a hospital, the Medicare program should reimburse them for a proportionate share of these costs.

The Secretary has great leeway to formulate standards for the determination of which are "reasonable costs" under 42 U.S.C. §1395x(v)(1)(A). In 1966, the Secretary promulgated the following regulation, now challenged by the plaintiffs:

> §405.420 Bad debts, charity, and courtesy allowances.
>
> (a) *Principle.* Bad debts, charity, and courtesy allowances are deductions from revenue and are not to be included in allowable cost; however, bad debts attributable to the deductibles and coinsurance amounts are reimbursable under the program.
>
> (b) *Definitions*—(1) *Bad debts.* Bad debts are

amounts considered to be uncollectible from accounts and notes receivable which were created or acquired in providing services. "Accounts receivable" and "notes receivable" are designations for claims arising from the rendering of services, and are collectible in money in the relatively near future.

(2) *Charity allowances.* Charity allowances are reductions in charges made by the provider of services because of the indigence or medical indigence of the patient.

(3) *Courtesy allowances.* Courtesy allowances indicate a reduction in charges in the form of an allowance to physicians, clergy, members of religious orders, and others as approved by the governing body of the provider. Employee fringe benefits, such as hospitalization and personnel health programs, are not considered to be courtesy allowances.

(c) *Normal accounting treatment: Reduction in revenue.* Bad debts, charity, and courtesy allowances represent reductions in revenue. The failure to collect charges for services rendered does not add to the cost of providing the services. Such costs have already been incurred in the production of the services.

....

(g) *Charity allowances.* Charity allowances have no relationship to beneficiaries of the health insurance program and are not allowable costs. The cost to the provider of employee fringe-benefit programs is an allowable element of reimbursement.

From the above it will be noted that plaintiffs are specifically allowed to collect every penny of bad debts attributable to the deductibles and coinsurance amounts which Medicare patients fail to pay. In other words, payments are reduced in the first instance by applicable deductibles and coinsurance amounts, 42 U.S.C. §1395e; 42 C.F.R. §405.110(b). Notwithstanding such fact, the amount of these reductions is eventually paid to plaintiffs to the extent that plaintiffs are not otherwise able to collect the

same. 42 C.F.R. §405.420(a). Since the exact amount of the bad debts incurred by Medicare patients in the foregoing areas is reimbursed, it is logical to deny reimbursement, either directly or as an item of overhead, of similar losses of revenue attributable to non-Medicare patients, in keeping with the congressional policy as expressed in 42 U.S.C. §1395x(v)(1)(A).

With respect to charity allowances, this Court has previously held, in a case which would apply to a great many of the plaintiffs in this action, that the cost of services furnished to indigents because of the free care obligation imposed by the receipt of Hill-Burton Act funds are indirect costs within the meaning of the Medicare legislation and as such are proportionately reimbursable. *Johnson County Memorial Hospital, et al, v. Schweiker*, 527 F.Supp. 1134 (S.D.Ind. 1981). Beyond that, however, it is difficult to find a justification for the plaintiffs' position.

The Congress has said that costs attributable to non-Medicare patients are not to be borne by the Medicare program. All of the items excluded by 42 C.F.R. §405.420 (a) are just such costs or, more accurately, lack of revenue. The challenged regulation appears to be in complete harmony with both the letter and the spirit of the statute, and the decision of the Board with respect thereto is correct.

To summarize, the motion for partial summary judgment of plaintiff Indiana Hospital Association, Inc. is denied. The motion of the defendants to dismiss Cause No. IP 76-522-C for lack of subject matter jurisdiction will be granted. The final decision of the Secretary is affirmed, and summary judgment will be rendered in favor of the defendants in the consolidated cases.

Dated this 12 day of August, 1982.

/s/ S. HUGH DILLIN

S. Hugh Dillin, Judge.

HEALTH CARE FINANCING ADMINISTRATION

Decision of the Administrator

In the Case of:	)	Claim for:
	)	
INDIANA HOSPITAL ASSOCIATION GROUP APPEAL NO. 1	)	Provider Cost Reimbursement Determination of Reasonable Costs for Cost Reporting Period(s) Ending Various
Provider	)	
	)	
vs.	)	
	)	Review of:
BLUE CROSS ASSOCIATION/ MUTUAL HOSPITAL INSURANCE, INC.	)	PRRB Decision No. 79-D95 Dated: December 17, 1979
	)	
Intermediary	)	

This group appeal is before the Administrator, Health Care Financing Administration, for review on own motion of the decision entered on December 17, 1979, by the Provider Reimbursement Review Board. The review is undertaken pursuant to Section 1878(f)(1) of the Social Security Act, as amended [42 USC 1395oo]. Comments were received from a division of the Bureau of Program Policy requesting that the Board's decision on Issue No. 2 be reversed. On January 22, 1980, the parties were notified of the intention to review the Board's decision on that issue and of their right to submit comments during the course of this review. Comments were received from the Providers requesting that the Board's decision be affirmed on Issue No. 2. No comments have been received from the Intermediary and the time in which to submit them has passed. Accordingly, the case is now before the Administrator for final administrative decision.

ISSUES AS STATED BY THE BOARD

"Whether the intermediary properly disallowed reimbursement for the following items:

"1. Reimbursement for the cost of uncompensated services, including charity allowances and bad debts; and

"2. Reimbursement for a return on net assets (return on equity)?"

PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

Issue No. 1

"The Intermediary properly disallowed reimbursement for the cost of uncompensated services, including charity allowances and bad debts."

PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

Issue No. 2

"The Intermediary should have allowed reimbursement for a return on net assets. The adjustments are, accordingly, reversed."

SUMMARY OF THE DIVISION OF INSTITUTIONAL SERVICES REIMBURSEMENT'S COMMENTS

The Division recommended that the Board's decision on Issue No. 2 should be reversed because it is contrary to 42 CFR 405.1867 and 405.429. Under 42 CFR 405.1867, the Board is explicitly bound by the Medicare regulations. Under 42 CFR 405.429(a)(1), a return on equity capital is allowable only to proprietary providers. 42 CFR 405.429(b)(1) explains that the return is necessary to avoid withdrawal of capital and attract additional capital, since proprietary providers do not receive contributions or governmental assistance. The Bureau stated that the regulations allowing the return to proprietary providers only, are consistent with Section 1861(v)(1)(B) of the Act and Congressional intent. The Board improperly substituted its judgement for that of the Secretary in interpreting the law.

SUMMARY OF PROVIDERS' COMMENTS

The Providers commented that the decision of the Board on Issue No. 2 should be affirmed. Concerning the merits of the case, the Providers wrote that the Board's decision is in keeping with Section 1861 (v)(1)(A) and (B) of the Social Security Act, as amended, the U.S. Constitution, and is supported by the testimony, legal arguments, and the record before the Board.

The Providers made nine objections concerning the review of Board decisions as being illegal and unconstitutional. They objected to the Secretary's consideration of ad hoc unsolicited comments from persons not parties to the appeal as contrary to the law on "own motion" review, and the due process rights under the Fifth Amendment of the U.S. Constitution. They objected that the delegation by the Secretary to the Administrator, of the authority to review Board decisions, is contrary to the Social Security Act and a violation of the due process rights of the Providers. In addition, having staff assistance for preparing findings of fact and conclusions of law may usurp the authority of the Administrator by separately reviewing Board decisions.

The Providers objected to review because final rules establishing the proper standards of review are necessary in order to satisfy due process requirements, and that the present interim procedures are not satisfactory substitutes. The review of a Board decision using such standards are in excess of statutory authority. The Providers pointed out that a decision of the Board may be reversed only where it is clearly erroneous or not supported by the record. Also, the Providers were not timely and properly notified by the Secretary because the notification did not come directly from the Secretary. The Providers further objected that the "own motion" review process violates due process in that there is no hearing, opportunity for oral argument, or an opportunity to respond to argument.

EVIDENCE CONSIDERED

All the evidence that was before the Provider Reimbursement Review Board has been considered, including the sworn testimony of the witnesses, the position papers and exhibits by the parties. All communications and comments received from the Providers and the Division of the Bureau of Program Policy, after entry of the Board's decision have been made a part of the record. The complete statement of facts set forth by the Board in its decision is incorporated by reference and supplemented as follows:

The Providers in this group appeal are 68 not-for-profit or non-profit Indiana hospitals (Providers' Position Paper (PPP, p. 3, and Attachment 1)). These hospitals are all either church affiliated or are owned and controlled by voluntary foundations, or cities and/or counties, and range in size from 48 to 1,026 beds (Intermediary's Position Paper (IPP, p. 4)). The Providers are represented by the Indiana Hospital Association whose President, Elton Tekolste, and Chairman of the Board, Sister Martin, testified at the hearing. The Providers claimed payment for a return on equity capital in providing services to Medicare patients, and for an allocable portion of the reasonable cost of bad debts and charity care provided (PPP, p. 3).

The President of the Indiana Hospital Association testified that a hospital needs to receive some type of operating margin (profit) for capital purposes, for contingencies, and to offset the costs of bad debts and charity care (Transcript of Oral Hearing (Tr. 27-29)). He further testified that foundations and charitable gifts have become less of a factor in capital formation in recent years. Thus, it has become necessary for hospitals to issue bonds and incur long term debts (Tr. 30). Sister Martin testified that an operating margin is necessary to induce investors to purchase hospital bonds and to enable hospitals to pay off the bonds (Tr. 38).

The American Hospital Association, in its Statement on the Financial Requirements of Health Care Institutions

and Services, states on page 5: "Investors in for-profit health care institutions are entitled to a reasonable return on their investments." On page 12 this document states: "The formula should provide for a reasonable return on the investment in for-profit health care institutions." (PPP, Exh. P-36, pgs. 5 & 12). This was referred to during the hearing by a Board member who was appointed as a representative of providers and has been a delegate-at-large to the House of Delegates of the American Hospital Association.

The managing partner of the firm of Certified Public Accountants for the Indiana Hospital Association testified that in his opinion, the AHA document and the Medicare program have terminology differences. He testified that in the AHA they do limit the return on investment to proprietary institutions. The return is to pay dividends to shareholders and Federal Income Taxes. This witness testified, however, that the AHA recognizes price-level depreciation, whereas Medicare recognizes only historical cost depreciation. Under price-level depreciation, providers' capital requirements are met (Tr. 129-130).

LAW, REGULATIONS, AND OTHER GOVERNING CRITERIA

Section 1814(b) of the Social Security Act as amended [42 USC 1395f] sets forth, regarding the amounts to be paid with Medicare funds to providers of services, as follows:

> "(b) The amount paid to any provider of services with respect to services for which payment may be made under this part shall, subject to the provisions of section 1813, [1395e] be—
>
> "(1) the lesser of (A) the reasonable cost of such services, as determined under section 1861(v), [1395x] or (B) the customary charges with respect to such services; . . ."

Section 1861(v)(1)(A) of the Social Security Act, as

amended [42 USC 1395x], defines reasonable cost and sets forth the guidelines for regulations:

> "(v)(1)(A) The reasonable cost of any services shall be the cost actually incurred, excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services, and shall be determined in accordance with regulations establishing the method or methods to be used, and the items to be included, in determining such costs for various types or classes of institutions, agencies, and services; ...Such regulations may provide for determination of the costs of services on a per diem, per unit, per capita, or other basis, may provide for using different methods in different circumstances, may provide for the use of estimates of costs of particular items or services, may provide for the establishment of limits on the direct or indirect overall incurred costs or incurred costs of specific items or services or groups of items or services to be recognized as reasonable based on estimates of the costs necessary in the efficient delivery of needed health services to individuals covered by the insurance programs established under this title, ...Such regulations shall (i) take into account both direct and indirect costs of providers of services (excluding therefrom any such costs, including standby costs, which are determined in accordance with regulations to be unnecessary in the efficient delivery of services covered by the insurance programs established under this title)...(ii) provide for the making of suitable retroactive corrective adjustments where, for a provider of services for any fiscal period, the aggregate reimbursement produced by the methods of determining costs proves to be either inadequate or excessive."

Section 1861(v)(1)(B) of the Social Security Act, as amended [42 USC 1395x], provides for recognition of a return on equity capital to proprietary facilities furnishing extended care services:

> "(B) Such regulations in the case of extended care

services furnished by proprietary facilities shall include provision for specific recognition of a reasonable return on equity capital, including necessary working capital, invested in the facility and used in the furnishing of such services, in lieu of other allowances to the extent that they reflect similar items. The rate of return recognized pursuant to the preceding sentence for determining the reasonable cost of any services furnished in any fiscal period shall not exceed one and one-half times the average of the rates of interest, for each of the months any part of which is included in such fiscal period, on obligations issued for purchase by the Federal Hospital Insurance Trust Fund."

Section 1871 of the Social Security Act, as amended [42 USC 1395hh] explains the Secretary's authority in establishing regulations for the program:

"The Secretary shall prescribe such regulations as may be necessary to carry out the administration of the insurance programs under this title. When used in this title, the term 'regulations' means, unless the context otherwise requires, regulations prescribed by the Secretary."

Section 1878(d) of the Social Security Act, as amended [42 USC 1395oo(d)], states concerning decisions of the Provider Reimbursement Review Board the following:

"(d) A decision by the Board shall be based upon the record made at such hearing, which shall include the evidence considered by the intermediary and such other evidence as may be obtained or received by the Board, and shall be supported by substantial evidence when the record is viewed as a whole...."

Section 1878(e) of the Social Security Act, as amended [42 USC 1395oo(e)], sets forth:

"(e) The Board shall have full power and authority to make rules and establish procedures, not inconsistent with the provisions of this title or regulations of the Secretary, which are necessary or appropriate to carry out the provisions of this section...."

42 CFR 405.415(e) provides an incentive for funding of depreciation:

"(e) *Funding of depreciation.* Although funding of depreciation is not required, it is strongly recommended that providers use this mechanism as a means of conserving funds for replacement of depreciable assets, and coordinate their planning of capital expenditures with areawide planning activities of community and State agencies. As an incentive for funding, investment income on funded depreciation will not be treated as a reduction of allowable interest expense."

42 CFR 405.419 sets forth the following principle and definitions regarding interest expense:

"(a) *Principle.* Necessary and proper interest on both current and capital indebtedness is an allowable cost. However, interest cost incurred as a result of judicial review by a Federal court (as described in §405.454(1)) is not an allowable cost.

"(b) *Definitions*—(1) *Interest.* Interest is the cost incurred for the use of borrowed funds. Interest on current indebtedness is the cost incurred for funds borrowed for a relatively short term. This is usually for such purposes as working capital for normal operating expenses. Interest on capital indebtedness is the cost incurred for funds borrowed for capital purposes, such as acquisition of facilities and equipment, and capital improvements. Generally, loans for capital purposes are long-term loans.

"(2) *Necessary.* Necessary requires that the interest:

....

"(iii) Be reduced by investment income except where such income is from gifts and grants, whether restricted or unrestricted, and which are held separate and not commingled with other funds. Income from funded depreciation or provider's

qualified pension fund is not used to reduce interest expense...."

42 CFR 405.423(a) and (c)(1) concerns the principle relating to grants, gifts and income from endowments:

"(a) *Principle.* Unrestricted grants, gifts, and income from endowments should not be deducted from operating costs in computing reimbursable cost. Grants, gifts, or endowment income designated by a donor for paying specific operating costs should be deducted from the particular operating cost or group of costs."

"(c) *Application.* (1) Unrestricted funds, cash or otherwise, are generally the property of the provider to be used in any manner its management deems appropriate and should not be deducted from operating costs. It would be inequitable to require providers to use the unrestricted funds to reduce the payments for care. The use of these funds is generally a means of recovering costs which are not otherwise recoverable."

42 CFR 405.429(a)(1), (a)(2), and (b)(1) set forth the following on allowance for return on equity capital of proprietary providers:

"(a) *Principle.* (1) A reasonable return on equity capital invested and used in the provision of patient care is allowable as an element of the reasonable cost of covered services furnished to beneficiaries by proprietary providers. The amount allowable on an annual basis is determined by applying to the provider's equity capital a percentage equal to one and one-half times the average of the rates of interest on special issues of public debt obligations issued to the Federal Hospital Insurance Trust Fund for each of the months during the provider's reporting period or portion thereof covered under the program.

"(2) For the purposes of this subpart, the term 'proprietary providers' is intended to distinguish providers, whether sole proprietorships, partnerships, or

corporations, that are organized and operated with the expectation of earning profit for the owners, from other providers that are organized and operated on a nonprofit basis.

"(b) *Application.* (1) *Computation of equity capital.* Proprietary providers generally do not receive public contributions and assistance of Federal and other governmental programs in financing capital expenditures. Proprietary institutions historically have financed capital expenditures through funds invested by owners in the expectation of earning a return. A return on investment, therefore, is needed to avoid withdrawal of capital and to attract additional capital needed for expansion...."

42 CFR 405.1867 explains the sources of the Board's authority:

"In exercising its authority to conduct the hearings described herein, the Board must comply with all the provisions of title XVIII of the Act and regulations issued thereunder, as well as rulings issued under the authority of the Commissioner of Social Security (see 20 CFR 422.408). The Board shall afford great weight to interpretive rules, general statements of policy, and rules of agency organization, procedure, or practice established by the Medicare Bureau."

Section 553 of the Administrative Procedure Act, 5 U.S.C. 553 provides concerning rule making:

...

"(b) General notice of proposed rule making shall be published in the Federal Register, unless persons subject thereto are named and either personally served or otherwise have actual notice thereof in accordance with law....

"Except when notice or hearing is required by statute, this subsection does not apply—

"(A) to interpretative rules, general statements of policy, or rules of agency organization, procedure, or practice; ..."

Section 556(d) of the Administrative Procedure Act, 5 USC 556, provides:

> "(d) ...In...determining claims for money or benefits...an agency may, when a party will not be prejudiced thereby, adopt procedures for the submission of all or part of the evidence in written form."

Section 557(b) and (c) of the Administrative Procedure Act, 5 USC 557, provides:

> "(b) ...On appeal from or review of the initial decision, the agency has all the powers which it would have in making the initial decision except as it may limit the issues on notice or by rule...."
>
> "(c) Before a...decision on agency review...the parties are entitled to a reasonable opportunity to submit for the consideration of the employees participating in the decisions—
>
> "(1) proposed findings and conclusions; or
>
> "(2) exceptions to the decisions...and
>
> "(3) supporting reasons for the exceptions or proposed findings or conclusions.

Section 1878(f)(1) of the Social Security Act, as amended [42 USC 1395oo], provides:

> "(f)(1) A decision of the Board shall be final unless the Secretary, on his own motion, and within 60 days after the provider of services is notified of the Board's decision, reverses, affirms, or modifies the Board's decision...."

42 CFR 405.1875 concerning review of Board decisions provides:

> "(a) The Secretary, on his own motion and at his discretion, may elect to review any decision of the Board. A right to such review does not vest in parties to the Board's hearing.
>
> "(b) The Secretary will promptly notify all parties to the Board's hearing of his election to review the Board's decision and of the result of such review.

Section 5(b)(1) and 5(b)(2) of the Interim Procedures for Conducting "Own Motion" Review, 42 FR 44599, dated September 6, 1977, provides:

> "(1) *Submittals.* A party or a party's representative (or the Medicare Bureau, if an administrative policy interpretive of the Medicare program is involved) may submit, for consideration in the course of 'own motion' review, any exceptions to the Board's decision, and supporting reasons. Proposed findings of fact and conclusions of law, with supporting reasons, may also be submitted for consideration in the course of the review. These communications are to be submitted within 15 days from the date the Provider received notice of the Board's decision (with the certification statement described in section 2(b) showing that a copy of these communications was sent to the representative of the opposing party to the Board's decision).
>
> "(2) *Other Submittals.* In cases where the notice of review described in section 5(a)(2) has not been issued, but submittals have been received from a party or the Medicare Bureau, the opposing party will have 30 days from the date the Provider received notice of the Board's decision within which to submit any exceptions to the Board's decision or proposed findings and conclusions, and supporting reasons for the exceptions or proposed findings and conclusions, for consideration in the course of final agency review...."

Section 5(d) of the Interim Procedures for Conducting "Own Motion" Review, 42 FR 44599, dated September 6, 1977, provides:

> "(d) *Subsequent Action.* The Administrator's evaluation and analysis of the Board decision, complete with records, include the evaluation of timely filed exceptions to the Board's decision or proposed findings of fact and conclusions of law, and supporting reasons for the exceptions or proposed findings and conclusions. The Office of the Attorney-Advisor assists the Administrator in the evaluation of

cases. Decision making authority in 'own motion' review cases is reserved exclusively to the Administrator. A decision by the Administrator will be issued in every case in which timely submittals are received or where the Administrator believes a criterion for decision is met."

DISCUSSION AND EVALUATION

The entire record which was before the Provider Reimbursement Review Board has been examined, including the transcript of the oral hearing, all correspondence, position papers, exhibits, and post hearing briefs. The Board's decision has also been carefully reviewed, and comments received from the Division of the Bureau of Program Policy, and the Providers, have been noted by the Administrator.

Issue No. 1

Section 1862(a)(2) of the Social Security Act, as amended [42 USC 1395y], prohibits payment for services for which the recipient of the services has no legal obligation to pay. In this case, the Providers rendered free care, and the recipients of this free care were not required to pay for it. Therefore, any costs associated with the free care rendered under these circumstances are not allowable costs for Medicare reimbursement purposes.

The Board found that the Providers' bad debts and charity allowances arose from their failure to collect the charge for services rendered to patients other than Medicare beneficiaries. Therefore, they do not relate to care of Medicare beneficiaries and are not allowable under 42 CFR 405.451(a) and (b)(1).

To allow such costs for Medicare reimbursement purposes would be contrary to the objectives of the Law and Regulations that costs associated with individuals not covered by Medicare will not be borne by the Medicare program. This is clearly set forth in Section 1861(v)(1)(A) of the

Social Security Act, as amended [42 USC 1395x], 42 CFR 405.402(a), and 42 CFR 405.451(b)(1).

The Deputy Administrator agrees with the Board that the costs in this case do not qualify as allowable costs. 42 CFR 405.420 specifically prohibits reimbursement for the cost of free care or charity allowances. "Charity allowances" of a provider are reductions in charges made by the Providers, and bear no relationship to Medicare beneficiaries. The Provider's free care costs in this case fall under the definition of charity allowances in 42 CFR 405.420(b)(2).

Issue No. 2

This issue involves whether these 68 not-for-profit and non-profit hospitals are entitled to a return on equity capital, just as if they were proprietary providers. The Providers in this case are church affiliated, or are owned and controlled by cities and/or counties, or voluntary foundations.

The Board sustained their position and held that the Providers are entitled to a return on equity capital. The Board found that some financial allowance is mandated by the original Medicare Act. The Board unanimously held that providers must be paid an amount in excess of strict technical accounting costs, writing that the law makes no distinction between not-for-profit and proprietary hospitals. The Board noted that the original Regulations provided for an allowance equal to two percent of a provider's total allowable cost (20 CFR 405.428). This allowance applied to all providers, whether proprietary or not-for-profit. The Board held that:

> "The enactment of the Regulatory amendment limiting reimbursement to only proprietary hospitals is unjustified and not in conformity with the Medicare Act (§1861(v)(1)(A)). Section 405.429(a) is in disagreement with the Act, Congressional intent and all principles of Medicare reimbursement considered in the enactment of this program. Since the law is con-

trolling and of greater weight, the Board finds the Regulation subordinate and not applicable. The Board is further convinced that a review of the circumstances surrounding the enactment of the Regulatory amendment would show a total disregard for the health community."

The Board's decision exceeded the scope of the Board's authority. The Provider Reimbursement Review Board is an adjudicatory board established by the Congress to hear cases on cost report controversies involving at least $10,000 for accounting periods ending on or after June 30, 1973. This law was codified as 42 USC 1395oo. The Board is not responsible to determine whether or not properly promulgated regulations are consistent with the Act.

In enacting the original Medicare law, the Congress included Section 1871 of the Social Security Act, as amended [42 USC 1395hh]. By this Section, the Congress specifically mandated that "The Secretary shall prescribe such regulations as may be necessary to carry out administration of the insurance program under this title." Also, under Section 1861(v)(1)(A) of the Social Security Act, as amended [42 USC 1935x], the Congress required the Secretary to prescribe regulations establishing the methods to be used and items to be included in determining the reasonable costs of rendering health care services to Medicare beneficiaries. It is the Secretary who is made responsible by law for prescribing such regulations as may be necessary.

Section 1878(e) of the Social Security Act, as amended [42 USC 1395oo], authorizes the Board to make rules and establish procedures not inconsistent with the Medicare law and regulations. Section 1878(d) of the Act requires the Board's decision to be based on the record, including evidence obtained or received by the Board and supported by substantial evidence. The Regulations, 42 CFR 405.1867, likewise require the Board to comply with all the provisions of the Act and the Regulations. This Regulation

also requires the Board to afford great weight to interpretive rules and general statements of policy.

In its decision, the Board refused to apply a governing regulation which is clearly applicable. The Board ruled the Regulation as being contrary to the law. This the Board cannot do. The Board is empowered to interpret Medicare law and regulations, and to apply them to the evidence in a case. It is not authorized to set aside existing regulations and substitute policies of its own design. Accordingly, the Board's decision is completely beyond the scope of its authority, and constitutes reversible error.

It is the Providers' position the Medicare's failure to pay a return on equity capital to non-profit providers violates the Fifth Amendment to the Constitution. This is because under the circumstances, Medicare would not be paying its fair share of provider costs. The Providers stated that if this policy is based on the Medicare Act, then the Act itself is unconstitutional, or if based on the Medicare regulations, then the regulations are unconstitutional and contrary to the Medicare Act. It is also the Providers' position that the economic needs and realities in the health care industry today, require a profit be generated by both for-profit and not-for-profit providers, for survival.

The Provider's position and needs in this regard have been noted. However, the Deputy Administrator finds that matters concerning the constitutionality of statutes are beyond the competence of an administrative agency. These are matters which come under the jurisdiction of the Courts, not of the Board or of the Deputy Administrator.

Further, even if the Board had not found the Regulation to be "subordinate and not applicable", its decision is erroneous. The Regulation in question, 42 CFR 405.429, is clearly in keeping with the law and the legislative intent.

The original Medicare Act, including Section 1861(v)(1)(A), made no provision for a return on equity. However, this issue was one of the first additions to be con-

sidered. The legislative purpose of the proposed amendment was reflected by Senator Long:

> "What we sought was to guarantee to the individual who invested his funds in a facility organized for profit that he would receive a fair return on the money he had put into the operation. As the proposed medicare regulations stood he would have been only reimbursed for the actual costs of providing services with no specific return given on his investment.
>
> "There was some uncertainty on the part of the House conferees as to the extent to which proprietary facilities would have been reimbursed under the Senate amendment. This uncertainty was ultimately resolved in a manner agreeable to the conferees on both sides.
>
> "Basically, the conferees agreed that extended care facilities organized for profit should receive a reasonable return on net equity. The reasonable return would be at a rate one and one-half times the average rate of return received on new investment in the hospital insurance trust fund. This formula yields about a 7½ percent return at the present time...." (Cong. Rec. 27608, 10/19/66).

In endorsing this amendment, Congressman Byrnes commented that the amendment does make a step toward recognizing that some return on investment must be provided for proprietary nursing homes. He pointed out that, after the adoption of the conference report on the amendment, proprietary nursing homes would be paid on one basis and non-profit ones would be paid on a different basis. Representative Byrnes stated that the transfer of patients to nursing homes when hospitalization was no longer required was a means of savings for both the patients and the Medicare program.

Therefore, there was a need for more nursing home beds. It was believed that the non-profit organizations would be unable to supply a sufficient number of beds to meet the

needs of the aged. Therefore, he stated, an inducement was needed to increase the availability of beds in proprietary facilities (Cong. Rec. 28220, October 20, 1966).

The proposed amendment became Section 7 of P.L. 89-713 effective November 2, 1966. This was codified as Section 1861(v)(1)(B) of the Act, [42 USC 1395x]. This Section directs that:

> "(B) Such regulations in the case of extended care services furnished by proprietary facilities shall include provision for specific recognition of a reasonable return on equity capital, including necessary working capital, invested in the facility and used in the furnishing of such services, in lieu of other allowances to the extent that they reflect similar items...."

It is true that the law as enacted uses the words "extended care services furnished by proprietary facilities". The Conference Report on the equity capital amendment, however, clarified that:

> "The conferees expect that the Secretary of Health, Education, and Welfare will apply similar or comparable principles in determining reasonable costs for reimbursement of proprietary hospitals for services furnished by them." H. Rep. No. 2317, 89th Cong., 2nd Sess., p. 3 (October 19, 1966).

It was clear that the Congress intended that a return on equity capital was to be available only to proprietary providers. It was the Congressional intent that those who invested in health care facilities organized for profit should to receive a fair return on the money invested.

The Regulation that resulted was published in the Federal Register on November 22, 1966, at 31 FR 14808. Regulation No. 5, Section 405.429 provided for a return on equity capital only to proprietary providers.

The Board, in its decision, noted the connection between that final Regulation and the limiting of the two percent

Allowance in Lieu of Specific Recognition of Other Costs to one and one-half percent for proprietary providers in Section 405.428 of the Regulation. That Regulation permitted inclusion as an element of reasonable cost "...an allowance in lieu of specific recognition of other costs in providing and improving services amounting to 2 percent of allowable costs (with the exception of interest expense and the allowance of this principle) except that for proprietary providers the allowance shall be 1½ percent of allowable costs (with the exception of interest expense, the allowance under this principle and the return allowed on equity capital)."

The Board noted that when this was a proposed rule, the two percent Allowance in Lieu of Specific Recognition of Other Costs was said to be in consideration of, among other things, a reasonable return on equity capital for all providers, proprietary and non-profit alike. The Board reasoned that the retention of the full two percent Allowance in Lieu of Specific Recognition of Other Costs for non-profit providers indicates the intent to continue payment of a return on equity capital to non-profit providers. The Board found that this intent to pay a return on equity capital to non-profit providers was not eliminated with the subsequent removal of the two percent Allowance in Lieu of Specific Recognition of other costs, because this Regulation Section was removed as a budgetary matter only.

The Deputy Administrator disagrees with this finding by the Board. The two percent Allowance in Lieu of Specific Recognition of Other Costs was never intended to pay providers a specific return on their equity, but was established in response to apprehensions in the health care industry that providers might be reimbursed less than their full costs.

The minutes of Health Insurance Benefits Advisory Council meeting on May 10, 1969, explained that the allowance had been an outgrowth of consultation between

Medicare and the national organizations representing hospitals. The allowance had been instituted because it had been believed that the inexactness of then available cost-finding methods would result in failure to reimburse the full reasonable costs incurred in furnishing services to Medicare beneficiaries. It was subsequently eliminated, not merely because of budgetary considerations, but because it was no longer needed and unwarranted. It was found through experience that reimbursement under Medicare was quite adequate, and cost finding was sufficiently sophisticated to identify all true costs. Mr. Thomas Tierney, the then Director of the Bureau of Health Insurance, reported that:

> "Now, with almost 3 years of Medicare and Medicaid experience, we are able to determine from reported financial statements how hospitals have fared. It would appear that the fears of hospitals that payment for the aged under Medicare would be less adequate than previously were unwarranted. One of the reasons that hospitals appear to have been able to obtain quite adequate reimbursement from Medicare is that many have modified their charge structure and taken other steps to assure that the portion of cost determined payable by Medicare is quite complete. Hospitals are continuing to take additional steps toward securing maximum reimbursement from Medicare. As a result, an allowance for unaccounted-for costs appears to be less warranted now than it was 3 years ago." Health Insurance Benefits Advisory Council: AGENDA BOOK, Minutes, Chronological Summary of 26th Meeting at 9, (May 10, 1969).

It would appear that if a return on equity capital were paid to non-profit hospitals, Medicare would be paying a disproportionate share of provider costs. This is because the return is a profit rather than a cost. Under Section 1861(v)(1)(A) of the Act and the supporting regulations, Medicare reimburses all of a provider's reasonable costs in caring for Medicare beneficiaries. This includes a propor-

tionate share of the cost of capital investment related to patient care such as a building or equipment.

In this case, the Board found that non-profit providers need the funds from the return on equity capital for capital investment purposes, and to cover the costs of bad debts and charity allowances. However, under these circumstances, Medicare would be paying an amount in excess of its share of reasonable cost. This excess would be used to satisfy the burden of non-Medicare patients. This is contrary to the mandate in Section 1861(v)(1)(A) of the Act and the Board's finding in this regard is clearly erroneous.

Based on the specific wording of Section 1861(v)(1)(B) of the Act and 42 CFR 405.429, and the Congressional comments, the Deputy Administrator finds that a return on equity capital is not an element of reasonable cost for non-profit providers. It is not an out-of-pocket cost and was not the type of cost contemplated as reasonable, either direct or indirect, when Section 1861(v)(1)(A) was enacted. Section 1861(v)(1)(B) was enacted because under Section 1861(v)(1)(A) alone a return on equity capital could not be paid to proprietary providers. Therefore, the Board's reliance on Section 1861(v)(1)(A) in this regard is erroneous.

The Providers' comments concerning the Secretary's own motion review process have been noted. The Providers claimed denial of due process because a division in the Bureau of Program Policy recommended reversal of the PRRB's decision. The Bureau is the component within the Health Care Financing Administration charged with day-in-and-day-out supervision of policy in the administration of the Medicare program by the various contractual intermediaries throughout the Nation. It is obligated to assure that the Medicare laws and regulations are correctly applied by the intermediaries. As such, where the Bureau is of the opinion that a decision entered by the PRRB is erroneous, it is also entitled to make comments for consideration in the course of final agency review. Submittals

by the Bureau are appropriate under the Interim Procedures for conducting final agency review. These were published in 42 FR 44599, September 6, 1977, and are binding until a formal regulation can be promulgated. Morever, it is noted that the Bureau's comments were shared with the Providers. However, even if the Bureau had made no comments, or the comments were entirely ignored in this review, the Board's decision would still be reversible. The Board's decision abrogating the governing regulation is beyond its authority.

The Provider's objections to the Secretary's delegation of authority to review PRRB decisions have been noted. The delegations of authority to the Administrator of HCFA concerning the Medicare program is contained in Section F 30 of the Department of Health, Education, and Welfare's "Statement of Organization, Functions, and Delegations of Authority", published in the *Federal Register* on November 2, 1977, (42 FR 57351). This authority states, "...the Administrator, Health Care Financing Administration shall exercise...The authority vested in the Secretary under Title XVIII of the Social Security Act (42 USC 1395 *et seq*)." The *Federal Register* notice states further that, "The authority in 1878(f) (42 USC 1395oo(f)) may only be redelegated to the Deputy Administrator, Health Care Financing Administration."

The Providers' contention that the Administrator has no authority to review a determination of the Board when acting on behalf of the Secretary is incorrect. The proceedings under Section 1878(f)(1) are inextricably intertwined with the rest of the provisions of Title XVIII with respect to which the Administrator, beyond doubt, has authority to act on behalf of the Secretary. Further, the authority to review Board decisions has been properly delegated to the Administrator, Health Care Financing Administration, as a result of the Secretary's Departmental Reorganization Order (42 FR 13262-13263, March 9, 1977). This Reorganization Order continued in full force and effect all

regulations, rules, orders, statement of policy and interpretations with respect to the Social Security Act. Thus, the Administrator has the authority to review the Board's decisions. By Blanket Delegation of Authority, the Administrator re-delegated to the Deputy Administrator all authority vested in him by the Secretary's Reorganization Order, dated March 9, 1977. The redelegation also sets forth that it did not divest the Administrator's authority and responsibility.

The Providers have objected to the review power over PRRB decisions, claiming a lack of due process of law. This objection is rejected as contrary to the basic tenents of administrative law. The review of PRRB decisions by the Secretary of HEW is in keeping with responsibilities to administer the program, and as set forth by law. Under Section 1878(f)(1) of the Social Security Act, as amended, [42 USC 1395oo], authority is given to conduct an independent review of PRRB decisions.

The review by the agency is in accordance with the general requirements of the Administrative Procedure Act, 5 USC, chapter 5, subchapter II. Under 5 USC 557(b) "on review of the initial decision, the agency has all the powers which it would have in making the initial decision except as it may limit the issues on notice or by rule." In providing for "own motion" review by the agency in PRRB cases, Congress evinced no intent to restrict the regular scope of such review. Certainly, if Congress had wished to exempt PRRB decisions from the general standards for agency review, it would have expressly stated such an intent. In this case, the decision of the Deputy Administrator, HCFA, acting on behalf of the Secretary, constitutes the final decision of the Secretary and final agency action.

The Providers' presentation with reference to the Interim Procedures for conducting final agency review of PRRB decisions have been carefully studied. These Interim Procedures were published in the *Federal Register* [42 FR 44599-44600, September 6, 1977] reiterate the law

and regulations on review, §1878(f)(1) of the Social Security Act, as amended, [42 USC 1395oo] and 42 CFR 405.1875.

These Interim Procedures do also contain in ¶4, criteria for reversing, affirming, or modifying a decision of the PRRB. In essence, they do no more than provide for the issuance of a reviewing decision when a Board decision is not in keeping with the law or regulations. The only basic addition is in ¶4.B which requires issuance of a decision if exceptions to a Board's decision or proposed findings and conclusions have been timely submitted. This was added to benefit providers, as explained in ¶1.C. This was to avoid confusion as to when to appeal, in view of the law's 60-day time limits for both the administrative and judicial reviews.

To the extent that the Interim Procedures deal with procedures, they incorporate the standard concepts in §557(b) and (c) of the Administrative Procedure Act, [5 USC 557]. The rule-making requirements of §553(b) of the APA, [5 USC 553] call for general notice of rule-making to be published in the *Federal Register*, unless the persons affected by the provisions are either personally served or have actual notice of the provisions. Further, Subsection (A) of §553(b) exempts from the publication requirements "interpretative rules, general statements of policy, or rules of agency organization, procedure, or practice..."

Therefore, under the APA, to the extent that the Interim Procedures deal with procedural matters, no rule-making is required. In any event, the Providers had knowledge of the Interim Procedures because the Board furnished them a copy of the Procedures as an attachment to its decision. Further, the Providers' attorney is familar with these procedures having previously represented during final agency review.

With reference to the Providers' argument that they were not timely notified of the intention to review, it is obvious that they did have sufficient time to submit comments. They did, in fact, submit comments which have,

in fact, been considered. In any event, under ¶4.B.2 of the Interim Procedures, where submittals have been made, the opposing party has 30 days from the date the provider received the Board's decision to submit its comments, even though no notice of intent to review is issued. The review is automatic.

The Interim Procedures afford the parties the opportunity to submit comments for consideration in the course of the review. The Provider chose to make only general statements on the merits, with the remaining comments devoted to contesting the procedural propriety of the review.

On this review by the Deputy Administrator in the instant case, no procedural impropriety has been found. All comments received after entry of the Board's decision have been in writing and entered on the record, with copies sent to the parties. The parties were furnished an opportunity to respond to the notice of intent to review, and to the comments of the Bureau. They were notified of their right to submit the comments they would like to have considered in the course of this review. Their comments have been carefully considered by the Deputy Administrator. The record in its entirety, including the Board's decision, and all the comments received thereafter have been independently scrutinized and reviewed.

The Deputy Administrator finds that the Board's decision in this case was inconsistent with the law, and the regulations issued in accordance with the law, and was clearly erroneous.

FINDINGS OF FACTS

1. The Deputy Administrator adopts the Findings made by the Provider Reimbursement Review Board on Issue No. 1, concerning reimbursement for the cost of uncompensated services, including charity allowances and bad debts.

2. The amount of Medicare reimbursable costs in controversy in this group appeal exceeds $50,000 for the various cost reporting periods under appeal.

3. The Providers in this group appeal consist of 68 Indiana hospitals.

4. The Providers are all either church affiliated, or are owned and controlled by voluntary foundations or cities and/or counties.

5. The Providers were all organized as not-for-profit or non-profit hospitals.

6. The Providers sought payment of a return on equity capital by Medicare.

7. The Board's decision would allow payment of a full return on equity capital, the same as would be paid proprietary providers.

8. In accounting or financing terms, the return on equity capital is a profit on investment.

9. A return on equity capital paid by Medicare, increases a provider's net income and therefore, increases its retained earnings.

10. Retained earnings is a source of dividends to the owners of a proprietary corporation.

11. The Provider Reimbursement Review Board did not limit its review to whether the regulations were properly applied, but ruled on the validity of the regulations, themselves.

CONCLUSIONS OF LAW

1. The Deputy Administrator adopts the Conclusions made by the Provider Reimbursement Review Board on Issue No. 1, concerning reimbursement for the cost of uncompensated services, including charity allowances and bad debts.

2. Payment of a return on equity capital is not necessary

in the efficient delivery of needed health services under Section 1861(v)(1)(A) of the Social Security Act, as amended [42 USC 1395x].

3. The return on equity capital is not reimbursable to these Providers as an element of reasonable cost under Sections 1814(b) and 1861(v)(1)(A) of the Social Security Act, as amended [42 USC 1395f and x].

4. Recognition of a return on equity capital is provided for extended care services furnished by proprietary facilities under Section 1861(v)(1)(B) of the Social Security Act, as amended [42 USC 1395x].

5. The return on equity capital is payable to proprietary providers only, under 42 CFR 405.429(a)(1).

6. Being organized and operated on a not-for-profit or non-profit basis, the Providers do not meet the definition of "proprietary" under 42 CFR 405.429(a)(2).

7. The Provider Reimbursement Review Board lacks the authority to rule that a regulation is not in conformity with the law under Section 1878(e) of the Social Security Act, as amended [42 USC 1395oo] and 42 CFR 405.1867.

DECISION

The decision of the Provider Reimbursement Review Board on Issue No. 1 is affirmed. The Providers are not entitled to reimbursement for the cost of uncompensated services, including charity allowances and bad debts. The decision is reversed on Issue No. 2. The Providers are not entitled to payment of a return on equity capital.

THIS CONSTITUTES THE FINAL ADMINISTRATIVE DECISION OF THE SECRETARY OF HEALTH, EDUCATION, AND WELFARE

Date: February 15, 1980

/s/ E. M. Collier

Earl M. Collier, Jr.
Deputy Administrator,
Health Care Financing Administration

PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION
79-D95

Provider—Indiana Hospital Association Group Appeal No. 1	)	Date of Hearing—September 18, 1979
Provider Nos.—Various	)	
vs	)	Cost Reporting Period Ending—Various
Intermediary—Blue Cross Association/Mutual Hospital Insurance, Inc.	)	
	)	Case No.—78-385G

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ISSUES:

Whether the intermediary properly disallowed reimbursement for the following items:

1. Reimbursement for the cost of uncompensated services, including charity allowances and bad debts; and

2. Reimbursement for a return on net assets (return on equity)?

STATEMENT OF FACTS:

This case involves a group appeal under 42 CFR 405.1837 by a group of nonproprietary Indiana Hospitals listed on Appendix A who are seeking payment for an allocable portion of the reasonable cost of bad debts, charity, and a return on equity incurred in providing services to Medicare patients.

Appendix A sets forth all the Providers who are part of this Group Appeal, and the amounts in controversy, disregarding the application of lower of cost or charges. The total amount of Medicare reimbursement deemed to be in controversy is $23,260,797.00.

Each Provider filed its Medicare cost report for its fiscal year claiming payment for an allocable portion of the reasonable costs of bad debts, charity, and a return on equity. The Intermediary, by Notices of Program Reimbursement issued to each Provider, denied payment for those costs. The Parties have stipulated that the methodology used by the Providers, as it relates to a return on equity, is a fair and reasonable method of apportioning this item to the Medicare program, and further that the methodology used by the Providers, as it relates to the cost of bad debts and charity, represents a fair approximation of the portion of such costs which would be apportioned to the program, if such costs were found to be reasonable.

CITATION OF APPLICABLE LAW, REGULATIONS, AND PROGRAM INSTRUCTIONS:

Appendix

I. **Law—Title XVIII, Social Security Act, as amended, §1861(V)(1)(A), Reasonable Cost.**

II. **Regulations—42 CFR, Subpart D**

1. §405.402—Cost Reimbursement—General C
2. §405.420—Bad Debts, Charity and Courtesy Allowances D
3. §405.429—Return on Equity Capital of Proprietary Providers E
4. §405.451—Cost Related to Patient Care F
5. §405.452—Determination of Cost of Services to Beneficiaries G

CONTENTIONS OF THE PARTIES:

Providers

Issue No. 1—Bad Debts and Charity

The Medicare Act mandates that providers be paid the "reasonable costs" incurred by them in the care of Medicare patients. Section 1861(v)(1)(A); 42 U.S.C. §1395x(v)(1)(A).

The Medicare Regulations specify the elements of reasonable cost and the method of calculating and apportioning the amount of each element of cost which the Secretary must pay pursuant to the Medicare Act (42 CFR, Part 405). The Medicare Act states that the Secretary must consider, when prescribing Medicare Regulations, the principles generally applied by national organizations (which have developed such principles). The Secretary must, pursuant to the Medicare Act, ensure that the Medicare Regulations not cause costs with respect to Medicare patients to be borne by nonMedicare patients. Section 1861(v)(1)(A); 42 U.S.C. §1395x(v)(1)(A).

A hospital, including each Provider, incurs expenses to provide services to patients who do not pay for such services resulting in bad debts or charity. Such expenses, if the patient does not pay for them, must be paid by the remaining patients (or their third party payors) of the hospital. If the Secretary under the Medicare Act does not pay for any portion of such expenses, then the nonMedicare patients (or their third party payors) must bear the burden of such expenses. This effectively results in nonMedicare patients bearing costs substantially in excess of the costs borne on behalf of the Medicare patients. In other words, the nonMedicare patients are subsidizing the Medicare program for real costs of furnishing patient care.

The primary objective of any hospital, including the Providers, whether proprietary, nonproprietary, or public, is to furnish high quality health care. In reaching this objective, all hospitals, as do any business, inevitably incur costs in providing services to indigent persons as well as the costs of uncollectible bills.

Hospitals have limited alternatives in recovering such costs. Absorbing the full cost of such bad debt and charity costs would result in the loss of hospital capital and eventual insolvency of the hospital. Since hospitals must recoup all their costs in order in the long run to remain solvent, these uncompensated service costs of bad debts and charity must be recovered from direct pay patients and their third party payors.

Recovering the cost of bad debts and charity is "appropriate and helpful in developing and maintaining the operations of the patient care facilities and activities" of hospitals, including the Providers. Recovering the cost of rendering charity and bad debt services is a "common and accepted occurence in the field of the Providers' business activity.

Providing some charity services to patients unable to pay, for example, an open emergency room and participating in the Medicare program are required if

private nonproprietary hospitals are to maintain their tax exempt status under Section 501(c)(3) of the Internal Revenue Code. The expenses of providing charity and bad debt services are necessary and proper in rendering services by hospitals, including the Providers.

In accounting methodology, uncollectible amounts, such as bad debts and charity, are generally denominated as reductions from revenues. However, the uncompensated service costs incurred by hospitals in furnishing services to persons unable or unwilling to pay, resulting in bad debts and charity, *are nevertheless real costs*. Such costs must be recovered by the hospital in order to avoid deficits and ultimately insolvency. Such uncompensated service costs are treated as costs by hospitals for both budgeting and rate setting purposes and are reflected in payments made by private patients for hospitals services.

The Secretary of Health, Education and Welfare, the Health Care Financing Administration, and the local fiscal Intermediary have interpreted the Medicare Act and Regulations so as not to reimburse hospitals for any part of the uncompensated service costs of such hospitals resulting from bad debts and charity. Hence, the share of such uncompensated service costs otherwise allocable to Medicare patients is shifted to, and borne by, the hospitals' private paying patients (or their third party payors).

This results in higher payments by nonMedicare payors than on behalf of patients under the Medicare program for the same services. Such interpretation in the hospitals' nonMedicare patients and third party payors subsidizing, through higher payments, the economically inadequate reimbursement available for services provided to Medicare patients and is a confiscation of private hospital property for a public program, namely the Medicare program.

The Medicare Regulations provide that hospitals are to recover "all necessary and proper expenses for an institution in the production of services" so that the

Medicare Program meets the "actual costs of services to beneficiaries as such costs vary from institution to institution". 42 C.F.R. §405.402(a).

Furnishing uncompensated services and the cost of the same is a necessary and proper part of operating a hospital. The Regulations provide that "necessary and proper costs are costs which are appropriate and helpful in developing and maintaining the operation of patient care facilities and activities. They are usually costs which are common and accepted occurrences in the field of the Provider's activity." 42 C.F.R. §405.451(b)(2). The incurrence of costs associated with uncompensated services are common and accepted occurrences in the health care business just as in any other business operation. Thus, the Medicare Regulations specifically recognize that such costs should be paid as reasonable costs under the Medicare Act.

A private nonproprietary hospital, in order to maintain its tax exempt status under the Internal Revenue Code, must either (i) provide health care for patients without charge or at rates below costs in general, or (ii) operate an emergency room on a full time basis which is open to all persons needing care without regard to whether or not they are able to pay for such care, and have admissions open to patients under public programs such as Medicare. See Internal Revenue Service Revenue Ruling, *Rev. Rul. 56-185* and *Rev. Rul. 69-545* as it modifies *Rev. Rul. 56-185.*

Thus, providing charitable services either in general, or through the operation of a full time emergency room, is an ordinary and necessary cost of doing business as nonproprietary, tax exempt hospital. Accordingly, it is a necessary and proper expense of operating the hospital which is appropriate and helpful in developing and maintaining the operation of patient care facilities and activities.

The patients of the hospital, whether Medicare or nonMedicare, reap the benefits of the tax exempt status of

the hospital, such as lower interest rates from tax exempt bonds. Therefore, the costs associated with the maintenance of such status should be borne by all paying patients of the hospital, both Medicare and nonMedicare.

The Medicare Regulations (42 C.F.R. §405.520) state that bad debts, charity, and courtesy allowances "are deductions from revenues and are not to be included in allowable cost...." The Providers, however, are *not* purporting to include such "deductions from revenues" amounts, but rather are including only the amounts which are the *costs* of these uncompensated services.

To the extent that the Secretary interprets the Medicare Regulations to preclude recovery by hospitals of allocable portion of the reasonable costs of uncompensated services relating to bad debts and charity, the Secretary is violating the Medicare Act.

The principles established by the American Hospital Association provided for the recovery of the expenses associated with providing care to indigent patients and patients resulting in bad debts. To the extent that the Medicare Regulations are contrary to such principles, they are in violation of the Medicare Act which requires that the hospitals be reimbursed for the reasonable cost of services. Reasonable cost as interpreted by the national organization, namely the American Hospital Association, specifically recognized that costs of uncompensated services associated with bad debts and charity must be recovered in order to maintain the financial viability of hospitals.

Thus, the Medicare Act requires that all providers, including the Providers herein, be paid for the cost of bad debts and charity as part of "reasonable cost."

The current Medicare Regulations provide:

> "Bad debts, charity, and courtesy allowances are deductions from revenue and are not to be included in allowable cost...."

42 C.F.R. §405.420(a)

In so far as the above quoted regulation precludes, or the Medicare Regulations do not pay, any portion of the cost of bad debts and charity to the Providers, such regulations are contrary to Section 1861(v)(1)(A) of the Medicare Act which mandates that hospitals, including the Providers, be paid the reasonable cost, including direct and indirect costs, of providing services to Medicare patients.

Issue No. 2—Return on Equity

Pursuant to the Medicare Act as interpreted by the legislative history, the Secretary in promulgating the original Medicare regulations in 1966 found that an element of reasonable cost of *all* hospitals *included a return on equity.*

The Medicare Regulations, as initially issued in 1966, paid to *nonproprietary hospitals* a 2% allowance to cover certain capital costs of the hospitals including a return on equity. On May 2, 1966, the Department of Health, Education, and Welfare (DHEW) announced the substance of the proposed Medicare reimbursement guidelines. Under these guidelines, *both proprietary and nonproprietary hospitals* were to be paid an additional allowance equal to 2% of allowable costs. The Department explained the 2% allowance in the body of the proposed regulations as follows:

> "...it is the established practice of a significant number of third party purchasers, to include in payment for cost of services a factor in the form of an allowance.... This allowance is, in part, *in lieu* of a specific return on equity capital...." (Emphasis added).

Proposed HEW Regulations Part 405, 31 Fed. Reg. 7864, 7871 (1966).

In 1966 the Commissioner of Social Security in public addresses and in hearings before Congress specifically concluded that the 2% allowance was a part of reasonable cost under the Medicare Act and included a return on equity:

"...The 2% allowance provided for in our principles does the same thing.

"It is not a bonus but a part of basic cost.

"The allowance is limited to an amount which might be justified as a *minimum return for the use of equity capital...*

"The 2 percent allowance applies alike to profit and nonprofit organizations. Thus, the principles *avoid the anomalous result that would arise from reimbursing a profit making organization more than a nonprofit organization for rendering exactly the same service*— solely by reason of allowing return on investment in one case but not in the other." (Emphasis added).

Hearings on Reimbursement Guidelines for Medicare Before the Senate Committee on Finance, 89th Cong., 2d Sess., at 55-56 (1966).

The Commissioner of Social Security further noted later in the *1966 Hearings*:

"SENATOR ANDERSON. On May 2, you said:

'In my opinion, the overwhelming majority of the hospitals would participate without the 2% factor.' "'If that is true, why did you put it in'?

"MR. BALL. 'I believe it is necessary in order to carry the provision in the law that says *the full cost for older people should be met from Medicare, and we are to avoid shifting any of the cost of older people to younger.* The 2% factor is to make up for certain unrecognized specific *real costs* in the rest of the formula.'" (Emphasis added).

1966 Hearings, at 72.

The Health Insurance Benefits Advisory Council ("HIBAC") as it was required to under the Medicare Act, reviewed and approved the proposed Medicare Regulations before they were published in June, 1966. HIBAC had previously discussed the need to provide in the Medicare

Regulations for payment to hospitals of *all costs*, including a return on equity or imputed interest.

HIBAC's detailed consideration of the need to pay hospitals for a return on equity or "imputed interest," resulted in the preparation and sending of a letter dated February 9, 1966 to Secretary of Health, Education, and Welfare, John W. Gardner, which concluded that "most members of the Council believe that strong arguments can be advanced in support of the inclusion of this factor (*i.e.*, a return on equity or imputed interest) as an element in reasonable costs."

The 2% allowance was adopted in 1966 by the Secretary in response in part to HIBAC's conclusion on the need for payment of a return equity. As the Commissioner of Social Security informed HIBAC:

> "After long and careful deliberation, during which the Council's conclusion that the case for payment for the use of equity capital had considerable merit as well as the representations of the AHA were considered, a decision was made to allow, as an element of reasonable cost for both proprietary and nonproprietary providers, a payment equal to 2% of the costs otherwise allowed (with the exception of interest expense), subject to the limitation that this allowance not exceed a reasonable long-term interest rate on the provider's equity capital. *This allowance is partly in lieu of a direct interest return on the equity capital of providers....*" (Emphasis added).

Congress, after the passage of the Medicare Act, specifically recognized the propriety of providing a return on equity via the 2% allowance to nonproprietary hospitals. In the conference Report No. 2317, 89th Cong., 2d Sess. (1966) to Public Law 89-713, Congress recognized that:

> "It is expected that in recognition of this amendment, the 2% of operating costs which would be allowed, in lieu of specific allowances for 'other costs' under the proposed regulations of the Secretary of Health,

> Education, and Welfare will in the case of extended care services provided by proprietary facilities be reduced by one-fourth to a total of 1½% of the operating costs."

Thus, Congress specifically acknowledged the existence of the 2% allowance and the propriety of the same and provided for the reduction in such allowance to 1½% in the case of proprietary facilities which were to be paid a specific return on equity. As a result, the final Regulations issued by HEW specifically provided for a return on equity to proprietary hospitals; however, the 2% allowance was reduced to 1½% in the case of proprietary hospitals.

The difference between the 2% allowance and 1½% allowance included a return on equity for nonproprietary hospitals used in furnishing services to Medicare patients. The 2% allowance, which included a return on equity, remained in effect for nonproprietary hospitals until abruptly removed as a budgetary matter by the Secretary effective July 1, 1969.

On June 27, 1969, the Secretary promulgated amendments to the Medicare Regulations, effective July 1, 1969, which eliminated both the 1½% and the 2% allowance for any cost reporting period beginning after June 30, 1969. In a statement preceding the language effecting the change, the Secretary said:

> "This amendment is prepared to conform to the Department of Health, Education, and Welfare *budget policy* for fiscal 1970 in implementation of the President's Review of the 1970 Budget which was released on April 15, 1969, by the Executive Office of the President." (Emphasis added).

The HEW "history file" to said Medicare Regulation effecting the elimination does not indicate that the allowance was eliminated after a determination that it was not an element of the reasonable costs incurred by hospitals in providing services to Medicare patients. Such record

makes it clear that the elimination by the Secretary of the allowance in lieu of specific recognition of other costs was prepared pursuant to HEW directives to limit further increases in the cost of the Medicare program.

The Medicare Regulations to the extent that they deny to nonproprietary hospitals reimbursement for return on equity produce the "anomalous result" originally sought to be avoided by providing different interpretations of reasonable costs depending on the character of the institution, notwithstanding that the patient care services provided by each institution are the same.

There is no question that the nonproprietary hospitals, like any proprietary hospital, have equity capital within the definition of the Medicare Regulations. No section of the Medicare Act provided that proprietary hospitals should be paid on any different basis or in greater or lesser amounts than nonproprietary hospitals. The Medicare Act makes no distinction between proprietary and nonproprietary hospitals. The fundamental mandate of the Medicare Act is that the regulations must:

> "...take into account both direct and indirect costs of providers of services...in order that covered services to individuals covered by the insurance programs established by this subchapter will *not* be borne by individuals not so covered...." (Emphasis added).

42 U.S.C. §1395x(v)(1)(A).

This provision constituted the basic prohibition against cross subsidization.

Cost reimbursement rules and regulations should assure that hospitals will be paid for their actual costs, and that nonMedicare patients and third party payors will not be charged higher rates to make up for inadequate payments under the Medicare program. This implies, moreover, that nonMedicare patients and third party payors must not be required to pay more to nonproprietary hospitals than to proprietary hospitals for comparable services simply

because of the elements of cost which the Medicare program chooses to pay in one case and denies in another.

Every indication in the original Medicare Act was that proprietary hospitals and nonproprietary hospitals should be treated equally in the determination of the amount of the reasonable cost of the service to be paid. Similarly, neither the Conference Committee report nor the reports of the House and Senate Committees which considered the "reasonable cost" payment concept under the Medicare drew *any* distinctions among the types of hospitals for purposes of payment for services.

With the 2% allowance, there was at least some recognition of the "indirect costs" of return on equity which were mandated by the Medicare Act. However, with the elimination of the 2% allowance, the nonproprietary hospitals, including the Providers herein, are forced to pass on the nonrecognized indirect costs of a return on equity to other paying patients, contrary to the express provisions of the Medicare Act.

Even the current regulations under the Medicare Act recognize that "reasonable cost" requires the payment of reasonable costs of hospitals beyond the bare accounting costs of such hospitals. Regulation Section 405.402 provides in relevant part:

> "All necessary and proper expenses of an institution in the production of services, including normal stand-by costs, are recognized...thus, the application of this approach, with appropriate accounting support, will result in meeting *actual costs* of services to beneficiaries as such costs vary from institution to institution."

Regulation Section 405.451 provides that reasonable cost means:

> "...The regulations in this subpart take into account *both direct and indirect costs* of providers of services. The objective is that under the methods of

determining costs, the costs with respect to individuals covered by the program will not be borne by individuals not so covered will, not be borne by the program.

"(2) *Necessary and Proper Costs.* Necessary and proper costs are costs which are *appropriate and helpful* in developing and *maintaining the operation of patient care facilities and activities.* They are usually costs which are common and accepted occurrences in the field of the provider's activity." (Emphasis added).

Such regulatory language clearly contemplates payment for, and recognition of, costs beyond bare accounting costs. *A return on equity is an indirect cost which is necessary and proper* in developing and maintaining the operation of patient care facilities and activities of hospitals, including the Providers herein, and are costs which are common and accepted occurrences in the field of Providers' activities.

The Medicare program itself recognized the necessity for a nonproprietary hospital to earn a return on its equity. In order for a hospital in Indiana to obtain Medicare reimbursement for depreciation and interest on any significant capital expenditure, such expenditure must be approved under Section 1122 of the Social Security Act. To obtain such approval, one criteria which the expenditure must satisfy is that it be financially feasible. An important factor in determining financial feasibility is whether the hospital will be able to maintain a return on its equity.

Investors in proprietary hospitals expect that their investment will be efficiently used by hospital management taking into account all of the alternative uses of such capital in the provision of health care. Likewise, the providers of capital to nonproprietary hospitals, no matter the source of that capital, have the same right to expect that their investment will be efficiently used by hospital management taking into account all the alternative uses of such capital in the provision of health care. In both cases hospital management, as the managers of any business, should seek

and expect to be paid by all paying patients (Medicare and nonMedicare) for the use of its capital in the form of a return on equity.

A return on equity is a part of the real cost in providing patient care regardless of the status of the hospital as a proprietary or nonproprietary hospital. It is a part of the payment by private patients for health care services. It is basic that those using or benefiting from the use of hospital capital should pay for such use in the form of a return on equity.

In order for a hospital, either proprietary or nonproprietary, to go into the money market to raise capital funds, whether investor capital or debt capital, it must have a return on equity. A hospital that does not have a history of earning a return on equity, nor an expectation of earning a return on equity, will not be able to incur debt in order to raise funds with which to replace plant and equipment and/or expand plant and equipment.

The Providers cannot stay financially viable if they do not receive sufficient revenues to maintain a return on equity. Reimbursement strictly on an accounting cost basis would not maintain the financial viability of any business, including a hospital business, and would result in the eventual insolvency of the business.

A return on equity is a "reasonable cost" of providing health care to patients by hospitals, including the Providers herein. There is no support in the Medicare Act or Medicare Regulations for the Secretary's current position that assets of nonproprietary hospitals should be used to subsidize a government program anymore than assets of proprietary hospitals should be used to subsidize a government program without any payment for the use of those assets in the form of a return on equity.

The Board should find that the Medicare Act requires all hospitals, both proprietary and nonproprietary to be paid for the use of their assets in the form of a return on equity.

The Medicare Act prescribes that the Secretary must pay all necessary costs, both direct and indirect, of providing services to Medicare patients. The Medicare Act mandates that the cost of providing services to Medicare patients shall not be shifted to nonMedicare patients.

Insofar as the Medicare Regulations do not provide a return on equity to the nonproprietary Providers they are contrary to Section 1861(v)(1)(A) of the Medicare Act which mandates that hospitals, including the Providers, be paid the reasonable cost, including direct and indirect costs, of providing services to Medicare patients. Accordingly, under the Medicare Act, the Board should sustain the Providers' claim for payment of an allocable portion of the reasonable cost of a return on equity.

Intermediary

Issue No. 1—Bad Debts and Charity

The Intermediary takes two positions in support of its adjustments to disallow the group members cost of uncompensated services (including charity allowances and bad debts):

1. Medicare regulations unequivocally prohibit the inclusion of bad debts and charity allowances in allowable costs.

2. Medicare regulations limit reimbursement to the cost of care for Medicare beneficiaries. The bad debts and charity allowances claimed by these providers relate to the care of nonMedicare beneficiaries and, therefore, would not be part of the cost of care for Medicare beneficiares.

The Intermediary considers these two positions adequate support for its adjustments.

Sections 405.420(a) and 405.420(b)(1) of the Regulations clearly state the principle that bad debts are not allowable costs. The Providers' bad debts are unquestionably reductions in revenues resulting from the failure to collect

for services rendered. Therefore, the Intermediary's adjustments to remove the Providers' bad debts from Medicare allowable costs are necessary to satisfy the requirements of §405.420 and for the proper statement of reimbursable costs.

The concept that bad debts are only reimbursable for deductibles and coinsurance amounts is discussed in the Provider Reimbursement Manual (HIM-15), §304, and provides clear instructions for the cost treatment of bad debts:

> "Bad debts resulting from deductible and coinsurance amounts which are uncollectible from beneficiaries are not includable as such in the provider's allowable costs; however, unrecovered costs attributable to such bad debts are considered in the Program's calculation of reimbursement to the provider."

This section clearly supports the application of §405.420. Bad debts are not includable in allowable costs, but bad debts related to unpaid beneficiary deductibles and coinsurance amounts are included in program reimbursement to the provider. Section 405.451(a) discusses costs related to Medicare beneficiaries' care. This section states in part:

> "All payments to providers of services must be based on the *reasonable cost* of services covered under title XVIII of the ACT and *related to the care of beneficiaries.* Reasonable cost includes all necessary and proper costs incurred in rendering the services, *subject to principles relating to specific items of revenue and cost.*" (Emphasis added).

Section 405.451(a) states reimbursable program costs *must* be related to the care of Medicare program beneficiaires. The Providers' bad debts, in controversy, arose from the Providers' failure to collect the charges for services rendered to patients other than Medicare beneficiaries. To include these bad debts as reimbursable program costs would be in violation of section 405.451(a).

In addition, §405.451(a) indicates program payments will be based on reasonable costs incurred in rendering covered services, subject to the principles relating to specific items of revenue and cost. The provision in §405.4210(a), that bad debts "are not to be included in allowable costs," *is a principle.* It addresses a specific item of revenue and cost (bad debts). Thus, bad debts would be subject to this Regulation. Claiming bad debts as allowable costs is contrary to both §405.420 and §405.451.

Section 405.451(b)(1) defines reasonable cost in the following manner:

> "Reasonable cost of any services must be determined in accordance with regulations establishing the method or methods to be used, and the items to be included. The regulations in this subpart take into account both direct and indirect costs of providers of services. The objective is that under the methods of determining costs, the costs with respect to individuals covered by the program will not be borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne by the program." (Emphasis added).

The objective of §405.451(b)(1) is to have the program bear only the cost of Medicare beneficiary care. Costs of non-beneficiary patient care are to be excluded from reimbursement.

Bad debts are reductions in charges caused by the inability to collect for services rendered. Since program patients are covered for care received and the deductibles and coinsurance amounts the beneficiaries cannot pay, the bad debts claimed to not relate to these patients. Therefore, since the bad debts are for care received by non-Medicare patients, claiming those bad debts as reasonable costs is an obvious attempt to have the program pay a portion of the cost of non-beneficiary patient care.

The Regulations do not permit reimbursement for non-Medicare patient's care. Reimbursement is limited to the

cost of beneficiary care. The Providers' attempt to receive reimbursement for bad debts is clearly inconsistent with §405.451(b)(1).

The issue concerning whether or not bad debts and charity allowances should be included in allowable costs was reviewed by HIBAC in their discussions prior to proposing program regulations on this matter.

Some of the reasons considered by HIBAC for treating bad debts as a deduction of revenue were as follows:

A. Bad debts result from uncollectible amounts due for services rendered. The failure to collect the charges results in a reduction of the revenue finally received, but does not add to the costs. The costs have already been incurred in the production of services.

B. The Medicare program could actually reduce the losses of hospital income from bad debts by paying the full cost, except for the deductible, for substantially all patients over 65 years of age.

C. Another consideration is the approach under generally accepted accounting principles. It was noted bad debts are often treated as a financial or selling expense; however, it was also noted the realization principle of income measurement requires that bad debts be deducted from revenue.

An opinion was also requested from the Office of the General Counsel. The conclusion was that if bad debts were allowed as a cost factor, there must be a proper cost apportionment between program beneficiaries and non-beneficiaries, as required by section 1861(v) of the Social Security Act. Therefore, only "bad debts" resulting from non-payment of beneficiary charges, i.e., the deductible and coinsurance amounts, would be included for Medicare reimbursement.

The Intermediary also believes that the Providers' contention that regulations support their position that uncollectible charges should be excluded from the apportionment calculation *is incorrect* and is *inconsistent*

with the methods of determining costs of covered services to beneficiaries.

To illustrate the proper mathodology of determination of cost of services to beneficiaries, the following example of four patients receiving an identical service in a hospital radiology department is offered:

Patient A—Medicare Beneficiary
Patient B—Private Pay Patient
Patient C—Hospital provides services @ 20% discount,
Patient D—Refused to pay bill.

—Total cost related to the four patients' services is $180.

—Each patient is charged the regular rate for the service received —$50.

Under the RCCAC cost reimbursement formula, the cost allocation would be as follows:

Patient Pay Type	Total Charges	Percent of Total Charges	Total Charges Used for Cost Apportionment	Total Costs Under RCCAC Cost Apportionment	Percent of Total Costs
A	$ 50.00	25%	$ 50.00	$ 45.00	25%
B	50.00	25%	50.00	45.00	25%
C	50.00	25%	50.00	45.00	25%
D	50.00	25%	50.00	45.00	25%
Totals—All Patients	$200.00	100%	$200.00	$180.00	100%

Note that under the RCCAC cost apportionment formula *all patients* are charged the same amount for the same service. Also, the cost for each patient is the same. The cost should not vary based on ability or willingness of the patient to pay for the services received. The costs should relate to the charges.

The Providers contend that not all charges should be used in the cost apportionment, instead, only the "paid" charges should be used. Under this method, the cost allocation would be as follows:

Patient Pay Type	Total Charges	Percent of Total Charges	Total Charges Used for Cost Apportionment	Total Costs Under Provider Proposed Cost Apportionment	Percent of Total Costs
A	$ 50.00	25%	$ 50.00	$ 45.00	25%
B	50.00	25%	50.00	45.00	25%
C	50.00	25%	50.00	45.00	25%
D	50.00	25%	50.00	45.00	25%
Totals—All Patients	$200.00	100%	$200.00	$180.00	100%

If we believe the Providers' contention, the cost to Medicare is $64.28 (except for Lower of Cost or Charges), and the cost to the private pay patient is also $64.28. However, the hospital would only collect $50 (the total charge) from the private pay patients. The collection from Patient C would only be $40 (the total charge less then 20 percent discount), even though the cost would compute as $51.44. For Patient D, the Provider would show no cost. Thus, even though the cost of rendering an identical service to each patient should be the same, the Providers' cost formula would show different amounts for each patient.

We do not believe the cost apportionment formula proposed by the Providers meets the requirements of the regulations. The charges used in this allocation have no relationship to cost. The charges recorded by the Provider were not the charges used in the cost apportionment formula.

Similar cases have been heard before the Provider Reimbursement Review Board. One recent case cited is *Hearing Decision 79-D48.* Although the facts are different, the principle remains the same that charges must include charges to all patients whether program beneficiaries or other patients and no exceptions can be made for charges which are known, or found to be at some future date, uncollectable. The Board, in its decision, found that §405.452(b) requires that all patient charges must be used to calculate the denominator of the ratio. There is no provision made for excepting from total patient charges uncollectable charges.

Issue No. 2—Return on Equity

The Intermediary takes two positions to support its adjustments disallowing the return on net assets (equity capital) on the group members' cost reports:

1. Medicare regulations do not provide for the reimbursement of a return on equity capital of non-proprietary providers.

2. Medicare regulations limit reimbursement to the cost of care for Medicare beneficiaries. An allowance for the return on equity capital of non-proprietary providers is not recognized as an element of the reasonable cost of covered services furnished to beneficiaries.

The Intermediary considers these two positions adequate support for its adjustments.

The concept that a return on equity capital is only includable as a reimbursable cost for proprietary providers has been continually enforced by the Medicare program. Provider Reimbursement Manual (HIM-15), §1200, restates the basic principles and definitions cited in reference to Regulation sections 405.429(a) and 405.429(a)(2), respectively.

This section clearly supports the principle set forth in Regulation §405.429(a). A return on equity capital is reimbursable as an element of the reasonable cost of covered services to beneficiaries by proprietary providers.

Section 405.451(a) of the Regulations discusses cost related to patient care for Medicare beneficiaries and states in part:

> "Principle. All payments to providers of services must be based on the reasonable cost of services covered under Title XVIII of the Act and related to the care of beneficiares. Reasonable cost includes all necessary and proper costs incurred in rendering the services, subject to *principles relating to specific items of revenue and cost.*" (emphasis added)

Section 405.451(b)(1) of the Regulations defines reasonable cost and states in part:

> "Reasonable cost. Reasonable cost of any services must be determined in accordance with regulations establishing the method or methods to be used, *and the items to be included.*" (emphasis added)

These sections express the concept that the regulations make provisions for specific items of cost which are considered to be properly includable in Medicare reimbursable cost. Conversely, there is no provision in the regulations which provide for a return on equity capital to non-proprietary providers.

Section 405.429(b) of the Regulations discusses the application of the principle related to return on equity capital for proprietary providers. This section states in part:

> "(1) Computation of equity capital. Proprietary providers generally do not receive public contributions and assistance of Federal and other governmental programs in financing capital expenditures. Proprietary institutions historically have financed capital expenditures through funds invested by owners in the expectation of earning a return. A return on investment, therefore, is needed to avoid withdrawal of capital and to attract additional capital needed for expansion."

This section of the regulations indicates the Secretary was concerned with providing for equitable treatment of both proprietary and non-nonproprietary providers. This concept is expressed in the general cost reimbursement provision. Section 405.402(b)(5) regarding Cost Reimbursement states:

> "(5) That the principles should result in the equitable treatment of both nonprofit organizations and profit-making organizations."

The concept that the Medicare reimbursement for a

return on net assets should be equitable for both proprietary and non-nonproprietary providers was also considered by HIBAC in their discussions prior to proposing the Medicare program regulations on this matter.

In regard to whether or not Providers should be allowed Medicare reimbursement for a return on net assets, some of the concerns of HIBAC were as follows:

A. Public Law 89-97 provides for reimbursement of reasonable costs, and an allowance above cost would be excessive.

1. However, it was felt such an allowance could be rationalized as "imputed interest expense" for the use of capital.

2. A paper entitled *Imputed Interest* was prepared for consideration at the December 16, 1965, meeting. The final analysis of this report was that Medicare reimbursement for "imputed" interest could possibly be justified for proprietary hospitals, but not for voluntary hospitals.

3. A primary reason HIBAC thought no reimbursement could be justified for an "imputed" interest to non-proprietary hospitals stemmed from the economics definition of "imputed" interest, referenced as follows: "...the rate of return implied from the use of one's own capital in a business enterprise." From an economic standpoint, the interest an investor could have received elsewhere on his investment represents a cost of using his own money to finance capital goods. It was further argued that imputed interest did not represent an item of economic cost for a non-profit provider.

B. Some of the other arguments considered by HIBAC in support of allowing a return on net assets to proprietary providers and not to non-proprietary providers were as follows:

1. Payment for the use of capital is necessary in the case of proprietary institutions because they do not share the access to philanthropic and Hill-Burton funds or favorable tax treatment enjoyed by voluntary institutions.

2. Without a return on capital, proprietary institutions would be unable or unwilling to participate in the Medicare program.

In consideration of these views, the Medicare Regulations only allow a return on equity capital as an element of the reasonable cost of covered services furnished to beneficiaries by *proprietary* providers.

Finally, we are in agreement with the conclusion which was reached in a previous case heard by the Blue Cross Association, which included the issue of whether or not the provider, a non-profit facility, was eligible for a return on equity capital (Blue Cross Association Provider Appeal Decision No. 00-19). In this case, the Hearing Officer affirmed the Intermediary's adjustment to disallow the return on equity, noting a non-profit facility is expressly prohibited from claiming such a cost in its Medicare reimbursement.

In conclusion the Providers, all non-proprietary institutions, have attempted to include in Medicare reimbursable costs an allowance for a return on equity capital. These amounts are not reimbursable under two separate sections of Medicare regulations. The program regulations and instructions are clear—this allowance is not an allowable program cost. The Intermediary's adjustments removing the allowance for a return on net assets (equity capital) from allowable costs for the non-proprietary providers are therefore necessary for the proper statement of reimbursable costs.

CONCLUSIONS AND FINDINGS:

The Provider Reimbursement Review Board, after consideration of the facts, parties' contentions, evidence

presented and testimony elicited at the Hearing, concludes and finds as follows:

Issue No. 1—Bad Debts and Charity

While the Board has addressed the subject of bad debts, etc. on a number of occasions, it has not had posed the basic dispute of "allowability" of such costs (other than coinsurance, deductible, etc.).

The Providers have admirably argued the logic of including a proportionate share of such costs in the computation of Medicare costs. Their arguments are, however, couched more in the concept of "equity" than in the realm of what the program has determined to be "reality." Notwithstanding the equity argument, the program specifically proscribes as an allowable cost, bad debts and charity allowances. Sections 405.420(a) and 405.420(b)(1) of the Regulations clearly state that they *are not allowable* costs. The program will reimburse for deductibles and coinsurance amounts which are unrecovered.

The logic herein is quite clear. Section 405.451(a) states reimbursable program costs must be related to the care of Medicare program beneficiaries.

The Providers' bad debts and charity allowances arose from their failure to collect the charges for services rendered to patients *other than Medicare beneficiaries.* Therefore, they do not relate to patient care, at least to the extent of the Medicare program. Section 405.451(b)(1) excludes from reimbursement costs of non-beneficiary patient care.

As stated by the Intermediary:

> "Bad debts are reductions in charges caused by the inability to collect for services rendered. Since program patients are covered for care received and the deductibles and coinsurance amounts the beneficiares cannot pay, the bad debts claimed do not

relate to these patients. Therefore, since the bad debts are for care received by non-Medicare patients, claiming those bad debts as reasonable costs is an obvious attempt to have the program pay a portion of the cost of non-beneficiary patient care."

The Board is also in agreement with the Intermediary that the cost apportionment formula proposed by the Providers does not meet the requirements of the Regulations.

> "All patients must be charged the same for identical services received, and all patient charges must be used in the apportionment of ancillary costs. We believe the Providers' contention that Regulations support their position that uncollectable charges should be excluded from the apportionment calculation is incorrect and is inconsistent with the methods of determining costs of covered services to beneficiaries, as prescribed by the...regulations."

While the arguments raised by the Providers receive Board sympathy, i.e., that all facilities should share their "bad debt and charity burdens" with all facets of the community, including the Medicare program, the Board is unable to alter its conclusion that the Regulations specifically do not allow it.

Therefore, the Board applies the controlling Regulations (§405.420(a) and 405.420(b)(1)) and affirms the Intermediary's adjustments.

Issue No. 2—Return on Equity

The Board's review of pertinent citations leads to its opinion that a Return on Equity Capital is an appropriate cost of not-for-profit providers.

Clearly, Congress intended to pay for *all* of the elements of actual costs (both direct and indirect) necessary to render services to Medicare patients and to pay the amount of *each* such element of cost claimed so long as it was reasonable.

The Medicare Act (P.L. 89-97), as enacted by Congress, provides that the Secretary of the Department of Health, Education, and Welfare ("Secretary") in promulgating Regulations under Section 1861(v)(1)(A) must:

> "...take into account *both direct and indirect* costs of providers of services...in order that, under the methods of determining costs, the necessary costs of efficiently delivering covered services to individuals covered by the insurance programs established by this subchapter *will not be borne by individuals not so covered*, and the cost with respect to individuals not so covered will not be borne by such insurance programs..." (emphasis added)

Pursuant to the Medicare Act the Secretary, in promulgating the original Medicare regulations in 1966, found that an element of reasonable cost of all hospitals *included a return on equity capital.*

The initial Regulations (1966) paid a 2 percent allowance to not-for-profit facilities to cover, among other things, certain capital costs *including* a return on equity capital. Following the issuance of proposed Medicare reimbursement guidelines (1966), providers were to be paid an allowance equal to 2 percent of allowable costs.

In 1966 the Commissioner of Social Security in public addresses and in hearings before Congress specifically stated that the 2 percent allowance was a part of reasonable cost under the Medicare Act and included a return on equity:

> "...The 2 percent allowance provided for in our principles does the same thing."
>
> *"It is not a bonus but a part of basic cost."*
>
> "The allowance is limited to an amount which might be justified as a *minimum return for the use of equity capital...*"
>
> "The 2 percent allowance applies alike to profit and nonprofit organizations. Thus, the principles *avoid the*

anomalous result that would arise from reimbursing a profit making organization more than a nonprofit organization for rendering exactly the same service—solely by reason of allowing return on investment in one case but not in the other." (emphasis added)

Hearings on Reimbursement Guidelines for Medicare Before the Senate Committee on Finance, 89th Cong., 2d Sess., at 55-56 (1966).

Both Congress and the Commissioner agreed on the treatment of return on equity capital. They both referred to the 2 percent allowance in lieu of specific recognition of other costs as a means of recognizing *indirect* costs. Again, these indirect costs included a return on equity capital *for all* providers.

A review of HIM-5, the program's original policy issuance denotes (allowance in lieu of specific recognition of other costs):

"*Principle*—In lieu of specific recognition of other costs in providing and improving services, an allowance amounting to 2 percent of costs allowed under the other principle (with the exception of interest expense) is includable as an element of reasonable cost of services, subject to the limitation that the allowance not exceed a reasonable long-term interest rate on the provider's net investment related to patient care."

Included in that section is a specific reference to the inclusion of not-for-profit hospitals, since only not-for-profit hospitals were eligible for Hill-Burton assistance:

"In the determination of the amount of the provider's net investment for purposes of applying this limitation, the cost of assets financed by Hill-Burton or other Federal funds will be excluded. Such exclusion will be on the basis of the share of the cost financed by Federal funds after adjustment for depreciation."

The 2 percent allowance remained in effect for not-for-

profit hospitals until removed "as a budgetary matter" by the Secretary in 1969.

The supporting language to the amendments to Medicare regulations which removed that element of cost makes no reference as to cause, other than to comply with budgetary considerations. One must wonder whether the Secretary considered, at all, the responses and comments made during the stage of notice of proposed rule-making. It seems unbelievable that a change in the Regulation deleting a necessary element of cost from reimbursement to not-for-profit hospitals would not have raised an enormous outcry. This is especially true since the program made no determination that return on equity capital was not an element of reasonable costs incurred in providing services to Medicare patients.

The Board's experience indicates that not-for-profit hospitals, like proprietary hospitals, have equity capital in line with the Medicare tenets. There is no rationale why one should be reimbursed differently than the other. In fact, the law makes *no* distinction. The recognition of the 2 percent allowance supports this. With the 2 percent allowance, there was at least some recognition of the "indirect costs" of return on equity capital, mandated by the Act. With the elimination of that allowance, all not-for-profit hospitals are forced to pass on the nonrecognized indirect costs of a return on equity capital to other paying patients.

The enactment of the regulatory amendment limiting reimbursement to only proprietary hospitals is unjustified and not in conformity with the Medicare Act (§1861(v)(1)(A)). Section 405.429(a) is in disagreement with the Act, Congressional intent and all principles of Medicare reimbursement considered in the enactment of this program. Since the law is controlling and of greater weight, the Board finds the Regulation subordinate and not applicable. The Board is further convinced that a review of the circumstances surrounding the enactment of the

regulatory amendment would show a total disregard for the health community.

The Board finds that its decision is consistent with the economic realities that exist, without exception, in all other industries. That is, a business entity must produce more revenue than expenses or it will cease to exist. The only difference in this case is that the excess of revenue over expense is not subject to distribution to shareholders, but is retained in the operation of the provider for future use. The financial requirements are the same for both not-for-profit and proprietary providers. The Medicare program clearly recognizes the need for a proprietary provider to develop capital for future use, (§405.429(b)(1)), and it is manifestly discriminatory to deny financial stability to the not-for-profit provider. Capital formation through government programs is a thing of the past and the current "charity" requirements of the Hill-Burton program, is doubly repressive since it is basically the existence of that program which is used to deny the return on equity payment; at the same time the Medicare program refuses to pay for the cost of those free services. Continued denial of these economic costs will directly lead to higher costs of health services as providers seek capital from the loan market.

The Board can find no reason for an allowance not be given to not-for-profit facilities for "other reasons," primarily inflation accounting. The Board finds that some financial allowance is mandated under P.L. 89-97. Since the Board is unanimous in its opinion that providers must be paid an amount in excess of strict, technical, accounting costs, it finds that not-for-profit providers must be paid an allowance similar to a return for the proprietary providers. The Board must rule that Return on Equity Capital is properly extended to not-for-profit providers. The Providers are sustained.

DECISION:

Issue No. 1

The Intermediary properly disallowed reimbursement for the cost of uncompensated services, including charity allowances and bad debts.

Issue No. 2

The Intermediary should have allowed reimbursement for a return on net assets. The adjustments are, accordingly, reversed.

Board Members Participating:

Arthur P. Owens
Carolyn B. Lewis
H. Joseph Curl
Harold Hinderer

FOR THE BOARD

December 17, 1979 Arthur P. Owens, Chairman

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF TEXAS
DALLAS DIVISION

BAYLOR UNIVERSITY MEDICAL CENTER	)	
Plaintiff	)	
	)	Civil Action
v.	)	No. 3-82-0986-H
RICHARD S. SCHWEIKER, Secretary OF U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES	)	
Defendant	)	

MEMORANDUM OPINION AND ORDER

Introduction

This case is before the Court on the parties' cross-Motions for Summary Judgment. The Court, after reviewing the record and the parties' Motions, is of the opinion that Defendant's Motion for Summary Judgment should be DENIED and Plaintiff's Motion for Summary Judgment should be GRANTED.

Facts

Plaintiff ("Baylor") filed its annual cost report for fiscal year ending ("FYE") June 30, 1979, pursuant to Defendant's (the "Secretary") regulation 42 C.F.R. §405.453(f). In its FYE 1979 cost report Baylor claimed a return on its net invested equity capital and computed its average per diem costs exclusive of labor and delivery room days. Baylor's fiscal intermediary disallowed Baylor's claim for a return on equity and recomputed Baylor's average per diem costs inclusive of labor and delivery room days. The fiscal intermediary's action resulted in a

reduction in Baylor's Medicare reimbursement in the amount of $2,629,259.

Baylor requested and received a hearing before the Secretary's Provider Reimbursement Review Board ("PRRB"). The PRRB affirmed the intermediary's disallowance of return on equity costs and reversed the intermediary on the labor and delivery area issue. The Secretary's Deputy Administrator, upon review of the PRRB's decision, held in favor of the Secretary on both issues, thus reinstating the intermediary's decision. The Deputy Administrator's decision represents the final decision of the Secretary which is reviewable by this Court pursuant to 42 U.S.C. §1395oo.

Labor/Delivery Area Costs

This issue, involving the same parties for a prior fiscal year (FYE 1978), was decided by this Court in an April 25, 1983, Memorandum Opinion, Civil Action No. 3-81-0266-H. The parties and issues being identical, the Court adopts its prior decision in *Baylor University Medical Center v. Schweiker*, CA-3-81-0266-H, in its entirety as it relates to labor and delivery area costs. Accordingly, Plaintiff's Motion for Summary Judgment on the labor/delivery area issue is GRANTED, and Defendant's Motion for Summary judgment on this issue is DENIED.

Return on Equity

The Medicare Act's[1] central reimbursement section provides that Medicare providers will be reimbursed their "reasonable costs" in providing health care to Medicare beneficiaries. 42 U.S.C. §1395x(v)(1)(A). The Secretary of Health and Human Services is directed to issue regulations determining which costs are reasonable. *Id.* On June 2, 1966, the Secretary published proposed regulations establishing "reasonable cost" reimbursement principles.

[1]Pub.L. No. 89-97, Title I, §102(a), 79 Stat. 313.

31 Fed. Reg. 7864 *et seq.* Included in the proposed regulations was what is presently codified as 42 C.F.R. §405.428, which provided for "an allowance amounting to two percent of costs allowed under the other [Medicare reimbursement] principles...as an element of reasonable cost...in lieu of a specific interest return on equity capital as well as other factors not given specific recognition [in these regulations]". 31 Fed. Reg. 7871.

On June 27, 1969, the Secretary repealed 42 C.F.R. §405.428. 34 Fed.Reg. 9927-9928. The Secretary concedes that the notice and comment procedures of the Administrative Procedures Act were not observed in repealing the two percent return on equity allowance. *Id.*

Contentions of the Parties

Baylor argues that the Secretary's repeal of the two percent return on equity allowance contravenes the Medicare Act and its legislative history, and that the Secretary's action in repealing the two percent allowance was in violation of the Administrative Procedure Act ("APA").

The Secretary contends that her action in withdrawing the two percent allowance for non-proprietary providers did not violate the Medicare Act, and was consistent with the Act's legislative history and amendments. The Secretary cites several recent decisions, all supporting her position on the substantive return on equity issue.[2] Concerning the procedural return on equity issue, the Secretary asserts that she was exempt from APA rules when she repealed the two percent allowance. Before it reaches the substantive issues, the Court feels it is

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[2]*Indiana Hospital Association v. Schweiker*, 544 F. Supp. 1167 (N.D. Ind. 1982); *Hospital Authority of Floyd County, Georgia v. Heckler*, No. 81-7835 (11th Cir. June 13, 1983); and *Saline Community Hospital Association v. Schweiker*, 554 F. Supp. 1133 (E.D. Mich. 1983); *St. Francis Hospital Center v. Heckler*, No. 82-2458 (7th Cir. Aug. 12, 1983) (per curiam *affirming* 544 F. Supp. 1167 (S.D. Ind. 1982)).

necessary to consider the procedural aspects of the Secretary's action.

Rule Making History

In June 1966 when the Secretary issued the proposed regulations which originally included the two percent return on equity allowance, the Secretary stated in the preamble of the regulations that:

> Notice is hereby given, pursuant to the Administrative Procedure Act...that the regulations set forth in tentative form below are proposed by the Commissioner of Social Security, with the approval of the Secretary of Health, Education and Welfare....
>
> Prior to the final adoption of the proposed regulations, consideration will be given to any data, views, or arguments pertaining thereto which are submitted... within a period of 30 days from the date of publication of this notice in the *Federal Register.*

31 Fed. Reg. 7864. The proposed regulations were adopted in final form in November 1966, the preamble of the final regulations acknowledging that the proposed regulations, including the two percent allowance, were filed, public comments received, changes in the proposed regulations made, and final regulations adopted, all in accordance with APA requirements. 31 Fed.Reg. 14808.

In June 1969, the Secretary repealed 42 C.F.R. §405.428, the two percent allowance, without following APA notice and comment procedures. In defense of her action the Secretary stated in the notice repealing the regulation:

> This amendment is prepared to conform to the Department of Health, Education and Welfare budget policy for fiscal 1970 in implementation of the President's Review of the 1970 Budget which was released on April 15, 1969, by the Executive Office of the President. For this reason, it is determined that compliance with the notice, public procedure, and

effective date requirements of the Administrative Procedure Act, 5 U.S.C. §553, is unnecessary.

34 Fed. Reg. 9927.

Statutory Framework

The applicable portions of the APA provide that:

> General notice of proposed rule making shall be published in the Federal Register....After notice required by this section, the agency shall give interested persons an opportunity to participate in the rule making through submission of written data, views, or arguments....After consideration of the relevant matter presented, the agency shall incorporate in the rules adopted a concise general statement of the basis and purpose.

5 U.S.C. §553. In certain specific instances agencies are able to avoid these notice and comment APA requirements "to the extent that there is involved...a matter relating to agency management or personnel or to public property, loans, grants, benefits, or contracts." 5 U.S.C. §553(a). Agencies are also exempt from APA notice and comment rules "when the agency for good cause finds...that notice and public procedure thereon are impracticable, unnecessary, or contrary to the public interest." 5 U.S.C. §553(b)(B).

Return on Equity—The Two Percent Solution

APA procedural guidelines "were designed to assure fairness and mature consideration" of agency rule making, *NLRB v. Wyman-Gordon Company*, 394 U.S. 759, 764 (1969). This Circuit has pointed out that:

> Congress realized that an agency's judgment would be only as good as the information upon which it drew. It prescribed these procedures to ensure that the broadest base of information would be provided by those most interested—and perhaps best informed—on the subject of the rulemaking at hand.

Brown Express, Inc. v. United States, 607 F.2d 695, 701 (5th Cir. 1979). APA notice and comment procedures were also intended to assure that a rule making agency considers relevant facts and information. *National Association of Home Health Agencies v. Schweiker*, 690 F.2d 932, 949 (D.C. Cir. 1982), *cert. denied*, 103 S.Ct. 1193 (1983).

The APA notice and comment requirements are specifically applicable to the repeal of a rule: "'rule making' [as defined in the APA] means agency process for formulating, amending or repealing a rule...." 5 U.S.C. §551(5).[3] In fact, where an agency decision, which was originally adopted in full compliance with APA notice and comment procedures, is reversed in the absence of notice and comment, such a decision is to be examined closely by the courts. *N.R.D.C. v. U.S. E.P.A.*, 683 F.2d at 760-1. "It would be meaningless to require notice and a reasonable opportunity to participate in rulemaking, if after announcement of a rule, the agency could closet its intent to reconsider and completely undo the rule first made." *Arlington Oil Mills, Inc. v. Knebel*, 543 F.2d 1092, 1100 (5th Cir. 1976).

Here, the Secretary used APA notice and comment procedures to promulgate the regulation granting non-proprietary Medicare providers a two percent return on equity allowance. Two years later, however, the Secretary repealed this regulation without using APA notice and comment procedures. The Secretary argues that her action repealing the regulation was exempt from APA notice and comment requirements since it involved a "benefit" program, thus qualifying for exemption from APA notice and comment under 5 U.S.C. § 553. (See Defendant's Reply Brief at 17-18).

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[3] *See also, Natural Resources Defense Council v. U.S. E.P.A.*, 683 F.2d 752, 762 (3d Cir. 1982); *Consumer Energy Council of America v. FERC*, 673 F.2d 425, 446 (D.C.Cir. 1982).

Granted, some pre-1971 Medicare regulations may qualify for an exemption from APA rule making procedures under the "benefits" exception to section 553(a)(2).[4] However, as recently noted by the Supreme Court, "(i)t is well-established that an agency's action must be upheld, if at all, on the basis articulated by the agency at the time of rule making". *Motor Vehicle Manufacturers Association v. State Farm Mutual Automobile Insurance Co.*, Supreme Court Slip Op. No. 82-354 at 19 (June 24, 1983); *Burlington Truck Lines v. United States*, 371 U.S. 156, 166-9 (1962); *Chenery v. S.E.C.*, 332 U.S. 194, 196 (1945). Here, as noted above, the Secretary did not in any fashion cite the "benefits" exception of 5 U.S.C. §553(a)(2) as her rationale for failing to use APA notice and comment procedures to repeal the Medicare two percent allowance for non-proprietary providers. Accordingly, longstanding administrative law principles prohibit the Secretary from claiming the "benefits" exception for the first time in this court to justify previous actions which were not, at the time, based on the "benefits" exception. As the Supreme Court has recently stated: "the courts may not accept...*post hoc* rationalizations for agency action." *Motor Vehicles Manufacturers Association v. State Farm, supra*, slip op. 82-354 at 19; *Burlington Truck Lines v. United States*, 371 U.S. at 168.

Even if the Secretary could avail herself of the "benefits" exception, this Circuit has held that agency action which has a substantial impact on affected parties, as this regulation's repeal most obviously does, is subject to notice and comment procedures. *See, e.g., Brown Express, Inc. v. United States*, 607 F.2d at 701-2; *National Association of Home Health Agencies v. Schweiker*, 690 F.2d at 949.

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[4] In 1971 the Secretary of HEW waived the "benefits" exemption to the APA for future rulemaking. Thus, pre-1971 Medicare regulations might be exempt under the "benefits" exception, but only if such exemption was claimed at the time the rulemaking action was taken. *See* discussion *infra*.

While not argued in this case by the Secretary, the only other exception which could serve as a basis for the Secretary's repeal of the Medicare regulation at issue is the "good cause" exception of 5 U.S.C. §553(b)(B) set forth above. Invocation of the "good cause" exception is implicit in the Secretary's explanation that the two percent allowance was being revoked to conform with the President's 1970 Budget, and that compliance with the APA was therefore "unnecessary". 34 Fed. Reg. 9927.

The Court is of the opinion that the Secretary's haste to comply with President Nixon's 1970 Budget Review is not a sufficient "good cause" to excuse compliance with established APA procedures. Futhermore, this Circuit has previously held that "the mere existence of deadlines for agency action, whether set by statute or court order, does not in itself constitute good cause for a section 553(b)(B) exception." *U.S. Steel Corp. v. U.S. E.P.A.*, 595 F.2d 207, 213 (5th Cir. 1979). Where a legislative or judicial timetable does not constitute good cause to ignore the APA, President Nixon's internal executive timetable for the release of the 1970 budget presents an even weaker attempt at constituting good cause to disregard the APA.

The Fifth Circuit has adopted the well-established rule that the APA's statutory exceptions from notice and comment procedures should be narrowly construed. *U.S. Steel Corp. v. U.S. E.P.A.*, 595 F.2d at 214. The narrow reading which this Circuit has given the good cause exception to the APA, when considered alongside the Supreme Court's stated concern with the importance of adherence to APA procedural requirements, and the Secretary's weak excuse for ignoring APA procedures when repealing 42 C.F.R. §405.428, prohibits the Secretary's repeal of the two percent return on equity allowance for nonproprietary Medicare providers from qualifying for the good cause exception to APA procedures.

The Secretary's action in repealing the two percent allowance in 1969 was a violation of the APA, and should be

declared invalid. Questions may arise as to the timeliness of the Court's ruling in this case, being 14 years after the Secretary's invalid action. These questions are not totally without merit. However, the Secretary points out in her brief that she "has broad authority in designing the regulations under the Social Security Act," and that her regulations interpreting the Medicare Act should be granted great deference by the courts. This deference has been recognized by the Supreme Court. *Schweiker v. Gray Panthers*, 456 U.S. 34 (1981). With such broad authority to interpret through regulations which are afforded great deference, it is crucial that the Secretary adhere to Congressionally mandated procedures for promulgating such weighty regulations. The procedures which must be followed are the notice and comment rules of the APA. Thus, where, as here, the Secretary clearly violates APA notice and comment procedures, a delay in bringing the violation to the courts' attention should not prevent judicial enforcement of the APA's requirements.

Baylor's delay in challenging the Secretary's repeal of the two percent allowance has not proven to be unfair to the Secretary. Baylor has forfeited reimbursement under §405.428 for FYE 1969-1978 since those cost report years are closed. Despite the Secretary's invalid repeal of §405.428, Baylor cannot challenge the millions of dollars in reimbursement denied through the Secretary's action. In addition, as the Supreme Court has explained in a similar situation, and as the D.C. Circuit has pointed out in the Medicare reimbursement context:

> if [powers are] granted, they are not lost by being allowed to be dormant, any more than nonexistent powers can be prescripted by an unchallenged exercise.

United States v. Morton Salt Co., 338 U.S. 632, 647 (1950); *National Association of Home Health Agencies v. Schweiker*, 690 F.2d at 948. Baylor's statutory right to challenge the Secretary's invalid repeal of §405.428 for

FYE 1979 is not lost by Baylor's failure to challenge in the past. Similarly, the Secretary's non-existent power to repeal §405.428 without APA procedures could not arise from Baylor's prior failure to challenge the Secretary on this issue.

Despite the acknowledged complexity of some policy areas, such as the Medicare reimbursement system, the Supreme Court recently struck down Congress' attempts to use the "legislative veto" as a means to supervise the implementation of complicated statutory policies. *I.N.S. V. Chadha*, Slip Op. 80-1832 (June 23, 1983). The APA, on the other hand, is a valid exercise of Congressional authority over administrative policy making. The APA violates neither the presentment clause, nor the constitutional principles of bicameralism or the separation of powers. As the APA is the only existing, constitutionally legitimate means for Congress to deal with the implementation of complex statutory policies, blatant agency avoidance of mandatory APA procedures should not be condoned by the courts. Furthermore, in spite of the acknowledged complexity of the Medicare reimbursement system, "[w]e nevertheless cannot abdicate our role in the regulatory process." *Gulf South Insulation v. United States Consumer Products Safety Commission*, 701 F.2d 1137, 1150 (5th Cir. April 7, 1983).

Where, as here, a court finds that an agency has violated the APA by failing to follow notice and comment procedures, the "reviewing court shall...hold unlawful and set aside agency action found to be without observance of procedure required by law." 5 U.S.C. §706(2)(D). *See also Chrysler Corp. v. Brown*, 441 U.S. 281, 313 (1979). The Court is therefore of the opinion that the Secretary's repeal of the two percent allowance was invalid, and the Plaintiff's Motion for Summary Judgment on the issue of the two percent allowance for return on equity capital should be granted for the reasons herein stated.

Accordingly, Plaintiff's Motion for Summary Judgment is hereby GRANTED, and the Defendant's Motion for Summary Judgment is hereby DENIED.

SO ORDERED.

DATED: September 13, 1983.

/s/ Barefoot Sanders

BAREFOOT SANDERS
UNITED STATES DISTRICT JUDGE